

Notices of Final Rulemaking

NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council or the Attorney General. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

Editor's Note: The following three Notices of Final Rulemaking were reviewed per Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 266.) The Governor's office authorized the notices to proceed through the rulemaking process on August 14, 2013.

[R14-02]

PREAMBLE

<u>1. Article, Part, or Section Affected (as applicable)</u>	<u>Rulemaking Action:</u>
R9-22-301	New Section
R9-22-302	New Section
R9-22-304	New Section
R9-22-305	New Section
R9-22-306	New Section
R9-22-307	New Section
R9-22-308	New Section
R9-22-309	New Section
R9-22-310	New Section
R9-22-311	New Section
R9-22-312	New Section
R9-22-313	New Section
R9-22-314	New Section
R9-22-315	New Section
R9-22-316	New Section
R9-22-317	New Section
Article 14	Amend
R9-22-1401	Amend
R9-22-1402	Repeal
R9-22-1403	Amend
R9-22-1404	Repeal
R9-22-1405	Repeal
R9-22-1406	Repeal
R9-22-1407	Repeal
R9-22-1408	Repeal
R9-22-1409	Repeal
R9-22-1410	Repeal
R9-22-1411	Repeal
R9-22-1412	Repeal
R9-22-1413	Amend
R9-22-1414	Repeal
R9-22-1415	Repeal
R9-22-1416	Amend
R9-22-1417	Repeal
R9-22-1418	Repeal
R9-22-1419	Repeal
R9-22-1420	Amend
R9-22-1421	Amend
R9-22-1422	Amend
R9-22-1423	Amend
R9-22-1424	Amend

Notices of Final Rulemaking

R9-22-1425	Repeal
R9-22-1426	Repeal
R9-22-1427	Repeal
R9-22-1427	New Section
R9-22-1428	Repeal
R9-22-1429	Amend
R9-22-1430	Repeal
R9-22-1431	Amend
R9-22-1432	Amend
R9-22-1443	Repeal
R9-22-1501	Amend
R9-22-1502	Repeal
R9-22-1503	Amend
R9-22-1505	Amend

2. Citations to the agency's statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. §§ 36-2903, 36-2903.01

Implementing statute: A.R.S. §§ 36-2901, 36-2901.07, 36-2903.01

Federal authority: 42 CFR Parts 431, 435, and 457

17144 Federal Register / Vol. 77, No. 57 / Friday, March 23, 2012 / Rules and Regulations

Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted on March 30, 2010), and together referred to as the Affordable Care Act of 2010 (Affordable Care Act)

3. The effective date of the rule:

January 7, 2014. The agency requests an immediate effective date upon filing with the Secretary of State as specified in A.R.S. § 41-1032(A). The agency believes this rulemaking meets the immediate effective date requirements under the following subsections:

2. To avoid a violation of federal law or regulation or state law, if the need for an immediate effective date is not created due to the agency's delay or inaction.

3. To comply with deadlines in amendments to an agency's governing statute or federal programs, if the need for an immediate effective date is not created due to the agency's delay or inaction.

4. To provide a benefit to the public and a penalty is not associated with a violation of the rule.

These exceptions apply to this rulemaking since the Affordable Care Act and ARS 36-2901.07 require the Administration to implement the higher federal poverty limit percentages and increase to the age limit for children in the foster care system. Therefore benefiting the public by providing coverage to more uninsured Arizona residents, The ACA requires this change to be effective January 1, 2014. Neither the ACA, the state statutes, nor the proposed rules impose any penalty for a violation of the rules. The Administration will rely on federal law for the first seven days of January until the rule is effective, no penalties or effects are associated with the different effective date. The Administration had to wait for CMS to approve the eligibility FPL requirements which caused a delay in filing.

4. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 19 A.A.R. 3154, October 11, 2013

Notice of Proposed Rulemaking: 19 A.A.R. 3064, October 11, 2013

5. The agency's contact person who can answer questions about the rulemaking:

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson St.
Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSrules@azahcccs.gov

Web site: www.azahcccs.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an

Notices of Final Rulemaking

explanation about the rulemaking:

The Administration is promulgating rule amendments as a result of the Affordable Care Act of 2010 and Arizona Laws 2013, First Special Session, Chapter 10 (House Bill 2010). Expansion of eligibility for: Children 6-18 to 133% of FPL, Former foster care children from ages 21 to 26, Childless adults up to 133% (including restoring Prop 204 populations, as described under A.R.S. § 36-2901.01, – up to 100% - and adding 100-133% per A.R.S. § 36-2901.07); Income determinations based on “modified adjusted gross income”; Changes to processes for determining and redetermining eligibility including changes to accommodate online applications and internet-based verification of income, citizenship and alien status, state residence, and other eligibility factors; and miscellaneous changes to clarify and conform to federal requirements. As directed by the ACA and A.R.S. 36-2901.07, the rules are to be effective January 1, 2014.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

A study was not referenced or relied upon when promulgating the state regulations for the Affordable Care Act.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable.

9. A summary of the economic, small business, and consumer impact:

The proposed rule changes will have a high impact on funds used for the coverage of Arizona Medicaid applicants. The Administration anticipates that for the first nine months of implementation for federal fiscal year (January 2014 through September 30, 2014) there will be a total fund expenditure of \$1,583,076,500 of both federal and state funds and for federal fiscal year (October 1, 2014 through September 30, 2015) there will be a total fund expenditure of \$2,768,972,900 of both federal and state funds.

	FFY 2014	FFY 2015
Eligible Adults with 100-133% FPL (aka Adult Expansion)	169,631,800	399,977,600
Childless Adults with 0-100% FPL	1,097,117,200	1,769,009,600
Newly Eligible children ages 6-18 with 100-133% FPL	68,636,700	127,443,400
Currently Eligible but not enrolled	247,396,400	471,762,200
Former Foster Children between ages 21-26	294,400	780,100
<u>GRAND TOTAL</u>	<u>1,583,076,500</u>	<u>2,768,972,900</u>

It is estimated that the cost and benefit of the increased coverage of individuals within certain federal poverty levels as directed by the Affordable Care Act will have an impact on the implementing agencies, contractors, providers, small businesses and consumers.

Minimal impact = up to \$1M

Moderate impact = \$1M to \$10M

High impact = \$10M on up

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

Changes were made between the proposed rulemaking and the final rulemaking as a result of the public comments submitted, see item 11, and rewritten items for clarity, such as where the Attorney Generals office is notified instead of Department of Homeland Security in rule R9-22-316. In addition, technical and grammatical changes have been made as a result of review from the Governor’s Regulatory Review Council.

11. An agency’s summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

Comments were received as of the close of the comment period of November 12, 2013.

Notices of Final Rulemaking

<u>Numb:</u>	<u>Date/ Commenter:</u>	<u>Comment:</u>	<u>Response:</u>
1.	11/12/13 Ellen Katz William Morris Institute for Justice	R9-22-301 Need to define the words “applicants,” “members” and “beneficiaries.”	Agreed. Changes made; beneficiary not used.
2.	11/12/13 Ellen Katz William Morris Institute for Justice	R9-22-302 This section does not refer to online applications and applications by telephone. Revise and reorganize to cover separately: (1) how someone can apply; (2) where someone can apply; (3) who can apply; and (4) what information must be provided. There appears to be no provision for an application by an emancipated minor.	The information about online applications is in Section 2. The rule draft is clear and concise and covers the noted subject areas. There isn’t anything in rule that prohibits an emancipated minor from submitting an application.
3.	11/12/13 Ellen Katz William Morris Institute for Justice	R9-22-304 (F) Propose that persons have at least 20 days to respond to requests for information. While the agency is helping the person obtain a Social Security Number, the agency must provide Medicaid to an otherwise eligible person. See 42 C.F.R. § 435.910.	The 10 day response time has been a long-standing practice (including in other states). In the event additional time is necessary, the applicant may request the additional time. These requests are routinely granted. The information about providing Medicaid while obtaining an SSN is covered under R9-22-305(2).

Notices of Final Rulemaking

4.	11/12/13 Ellen Katz William Morris Institute for Justice	<p>R9-22-305</p> <p>These rules fail to require compliance with federal requirements that the agency must affirmatively ensure that persons eligible for emergency medical services and persons applying for benefits on behalf of eligible children and adults are not deterred, based on national origin, from applying for benefits because the agency, in person or on applications, solicits or requires unnecessary information such as social security numbers and citizenship and immigration status.</p> <p>The rules need to explicitly state that AHCCCS will only seek and record information necessary to determine eligibility for a benefit and will not solicit or record information that is not necessary for that purpose.</p> <p>Paragraph 2. There are missing words. The rule must affirmatively state that a person applying for another household member or applying only for emergency medical assistance cannot be asked for a Social Security Number.</p> <p>Paragraph 3. The inclusion of the words “as of October 1, 2012” makes the sentence ambiguous and could be interpreted to mean that a person must reside in Arizona as of that date to be eligible for medical benefits which is not correct.</p> <p>Paragraph 4. The rule must affirmatively state that a person who is seeking only emergency medical assistance cannot be asked or required to sign a written declaration that they are a citizen, national or qualified alien.</p> <p>Paragraph 5. The list of documents to show immigration status is too restrictive. If more documents are not listed, the rule should reference the U. S. Department of Justice November 17, 1997, Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 http://www.gpo.gov/fdsys/pkg/FR-1997-11-17/pdf/97-29851.pdf.</p> <p>Paragraph 6. The rule must affirmatively state that a person who is only applying for emergency medical assistance cannot be asked about their immigration status, asked to sign a declaration or asked to produce immigration documentation.</p>	<p>Although R9-22-1403 was stricken in the Notice of Proposed Rulemaking (consistent with A.R.S 41-1001), because as it is redundant of federal law, this language has been restored to R9-22-1403 in the Notice of Final Rulemaking to provide additional clarity</p> <p>The rule does explicitly state the information that is required to determine eligibility. The direction to eligibility staff to not request unnecessary information is an internal procedure covered under policy.</p> <p>The Section has been revised for clarity.</p> <p>Section 3, has been updated to state “published on October 1, 2012”.</p> <p>This concern is addressed under subsection (6) of R9-22-305.</p> <p>The listing of documents are an example, this does not restrict the submission of the documents to only those listed. The Administration has updated this section cross-referencing 45 CFR 435.406 and 435.408.</p> <p>This concern is addressed under subsection (6) of R9-22-305. The rule states the person does not have to comply with sections 4 and 5, it is not necessary to repeat verbiage and it also states that they will receive emergency services only.</p>
----	---	---	--

Notices of Final Rulemaking

5.	11/12/13 Ellen Katz William Morris Institute for Justice	<p>R9-22-306</p> <p>Go through the rules to be sure “or its designee” is inserted in all places that “Administration” is used.</p> <p>Section A(6). The agency shall provide the person information explaining the requirement that the applicant or member obtain or provide a Social Security number. The rule must affirmatively state that this section does not apply to persons seeking emergency medical assistance.</p> <p>AHCCCS is required to assist a person to obtain a Social Security number. The actions AHCCCS must take pursuant to 42 C.F.R. § 435.910 should be listed as a subsection, possibly to A(5).</p> <p>Section A(12). Use of SAVE to verify eligible alien status. The rule must affirmatively state that this rule does not apply to persons seeking only emergency medical assistance.</p> <p>Section A(19)(a). Should include the words “without good cause.”</p> <p>Section A(19)(b). This section references 42 C.F.R. §433.148 which is the assignment of rights federal regulation. This sentence needs to be revised so that it is clear.</p> <p>Section B(2)(C). Refers to a Social Security Number, when the policy holder may not have one.</p>	<p>Agreed, updated where applicable.</p> <p>SSN requirements are covered under R9-22-305(2).</p> <p>SSN requirements are covered under R9-22-305(2). Your concerns have been addressed in the revision of R9-22-305(2).</p> <p>The Administration has revised this section for clarity.</p> <p>R9-22-306(A)(19) - The Administration disagrees because the federal regulations do not include an exception of “without good cause”.</p> <p>The Administration has revised this section for clarity.</p> <p>The Administration has revised this section for clarity by removing the SSN requirement.</p>
6.	11/12/13 Ellen Katz William Morris Institute for Justice	<p>R9-22-307</p> <p>Section B(3). Includes “resources” but there are no resource limits for Medicaid beneficiaries under the ACA.</p>	<p>No change is being made based on this comment. This section also applies to persons whose eligibility is determined using methodologies other than MAGI and that includes resource tests.</p>
7.	11/12/13 Ellen Katz William Morris Institute for Justice	<p>R9-22-312</p> <p>Section A. Contents of Notices. Should include how the notice was served and the date of the notice.</p> <p>Section C (3). For a person who cannot be located, this rule should include telephone and e-mail efforts and contacts with a person who the claimant has listed as someone who may know of his/her location.</p>	<p>The Administration has revised this section for clarity by including in the contents of the notice the date of the notice and explaining how it can be sent in the heading of the section.</p> <p>An applicant or member has an affirmative responsibility to maintain a current address on file as described under 42 CFR 435.916(b). Neither state nor federal law requires the agency to attempt to locate people who do not comply.</p>

Notices of Final Rulemaking

8.	11/12/13 Ellen Katz William Morris Institute for Justice	<p>R9-22-314</p> <p>Section B: This rule allows AHCCCS to discontinue eligibility for all household members if the notice of withdrawal does not identify a “specific person.” If no one is listed then the notice of withdrawal is incomplete and cannot be action upon. If the rule means no one else in the household is listed, then no one else should be withdrawn. This rule should be revised to be clear.</p> <p>Section C. The notice should go to all household members that are affected by the withdrawal.</p>	<p>The Administration has revised this section for clarity.</p> <p>The notice provided will list all affected members.</p>
9.	11/12/13 Ellen Katz William Morris Institute for Justice	<p>R9-22-315</p> <p>Section B. Notice of Adverse Action. (Relates to R9-22-312-Member Notices). Under the rules, a notice is sent 10 days prior to an action regarding eligibility or premiums. The date of the notice is the date personally served or the postmark date. These rules need to acknowledge that mailing can often take 5 business days and that time period should be added to the time to file an appeal.</p>	<p>This section complies with 42 CFR 431.211.</p>
10.	11/12/13 Ellen Katz William Morris Institute for Justice	<p>Article 14</p> <p>Under the ACA, the adjusted gross income (“AGI”) used in federal taxes with some modifications (called the Modified Adjusted Gross Income or “MAGI”) replaces the current Medicaid rules to determine financial eligibility for many eligibility categories. In general, the Institute strongly suggests that the AHCCCS rules follow the federal MAGI regulations. The federal MAGI regulation is 42 C.F.R. § 435.603. The current draft consolidates and rearranges and ends up getting things wrong or leaving important concepts out.</p> <p>1. The rule should affirmatively state there is no asset or resource limits tests for MAGI eligibility. <i>See</i> 42 C.F.R. § 435.603(g).</p> <p>2. The rule should affirmatively state who is excluded from the MAGI-based methodology. Those include persons receiving Supplemental Security Income (“SSI”), persons 65 or older when age is a condition of eligibility, persons who are blind or disabled, persons requesting long term services and supports, persons requesting Medicare and persons claiming they are medically needy. 42 C.F.R. § 435.603(g)(1-5).</p> <p>3. The definition “dependent child” is incorrect. Under 42 C.F.R. § 435.603(f)(iv), the state can elect age 19, or in the case of full-time students, age 21. Age 18 is not relevant.</p>	<p>Since the proposed amendment to the rule do not include an asset resource test neither the Administration or its designee can use that as a basis for denying eligibility therefore it is not necessary to affirmatively state that there is no asset test.</p> <p>The proposed rule identifies the people who are included in MAGI at R9-22-1427. The persons whose eligibility is determined based on something other than MAGI methodologies are listed in other Articles.</p> <p>The definition of a “dependent” child is used to determine if a person meets the definition of caretaker relative under 42 CFR 435.4. The commenter seems to confuse this definition with the definition of “child” in 42 CFR 435.4.</p>

Notices of Final Rulemaking

11.	11/12/13 Ellen Katz William Morris Institute for Justice	<p>R9-22-1420</p> <p>Section A: This is the traditional Medicaid income calculation, and there is no resemblance or reference to the MAGI-based income counting federal regulation at 42 C.F.R. § 435.603(e). There are special regulations for excluding some income to Native Americans that are not in the rules. 42 C.F.R § 435.603(e)(3).</p> <p>Section B. MAGI Income Group: Throughout the rules, the rules refer to “applicant” and “taxpayer.” Without clear definitions, these are ambiguous terms.</p> <p>1. By “applicant” AHCCCS seems to mean the individual seeking coverage. However, there are situations where an individual may fill out an application for coverage of a family member. In such cases, the term “applicant” is ambiguous. As noted previously, the rules should specifically define “applicant.”</p> <p>2. We believe “tax filer” is a more appropriate term than “taxpayer.” In this case the key action is the person who expects to “file” a return. But we also understand that the federal MAGI regulations use the term “tax payer.” We suggest inclusion of a reference that taxpayer is a person who expects to file a tax return.</p> <p>3. Our understanding is that there are 3 general categories of individuals: (1) Those who file taxes and are not claimed as a dependent by someone else; (2) those who file taxes and are claimed as a dependent by someone else; and (3) those who do not file taxes and are not claimed as a dependent by someone else. 42 C.F.R §435.603(f).</p> <p>Suggest that AHCCCS draft a “flow chart” that shows how MAGI household size is determined.</p> <p>Section B(1): This subsection seems to mimic 42 C.F.R. § 435.603(f)(1), but leaves out a key part. The federal regulation (f)(1) refers to a tax filer “who does not expect to be claimed as a tax dependent by another taxpayer.” Without this clause, the rule creates an ambiguity for dependents who also file taxes, who could then fit under subsection B(1) or (2). Also, the federal regulation refers to an exception if a tax filer cannot reasonably establish that someone is her dependent (f)(5). The rule makes no mention of that eventuality.</p> <p>Section B(2): This subsection deals with dependents living with a custodial parent. Again, it differs from the federal regulation and creates a potential problem. In this case, the problem is best exemplified in the case of families where a dependent child lives with both parents, but the parents are not married and file separately. By the federal regulation, the child in this situation would have a family of three (the child, the tax filer claiming them, and the second live-in parent) (see federal regulation exception at 42 C.F.R. § 435.603(f)(2)(ii).) But according to the draft rules, the MAGI household would only include the child and the custodial parent, because paragraph (c) refers to “The taxpayer’s spouse,” and in this case the second parent is not a spouse. Also, any live-in minor siblings of the child in this scenario should be included, regardless of whether they are claimed by the tax filer who claims the child. The draft rule does not seem to account for non-dependent live-in siblings. (see federal regulation 42 C.F.R. § 435.603(f)(3)(iii).)</p>	<p>This subsection merely provides a definition of “income.” It is not intended to include detail on specific types of income and treatment. That is covered by the CFR, which is referenced in the definition of MAGI-based income in R9-22-1401.</p> <p>Agreed. Added definitions of applicant in R9-22-301 and taxpayer in R9-22-1401 for clarity.</p> <p>Agreed. the taxpayer definition has been updated in R9-22-1401.</p> <p>Added definition of taxpayer to R9-22-1401. Added language to subsection (B)(6) to address regulation at 42 CFR 435.603(f)(5).</p> <p>Agreed. Revised for clarity within the definition of taxpayer in R9-22-1401.</p> <p>Revised for clarity</p>
-----	---	---	---

Notices of Final Rulemaking

		<p>Section B(3): There appear to be drafting errors that make this paragraph difficult to decipher. It seems to want to cover both the exception for determining household of individuals claimed by a non-custodial parent [see federal regulation 42 C.F.R. § 435.603(f)(2)(iii)] and the exception for individuals claimed by someone who is not their spouse or parent (42 C.F.R. § 435.603(f)(2)(i)). We suggest the concepts be separated.</p> <p>In any case, the reference to counting income should be deleted. This section is about determining the MAGI household for the individual seeking coverage, not whose income counts, which is dealt with in the draft rule, Section C. The rule should read: "...determine the applicant's MAGI income group as described in subsection 4(a) or 4(b), based on the applicant's age."</p> <p>Section B(4): This parallels federal regulation (f)(3) for non-tax filers, but there are again discrepancies.</p> <p>1. First, it again refers inappropriately to counting income, when it should only refer to determining the household size (the "MAGI income group.") Household size and household income should be separate calculations.</p> <p>Also, there are cases where dependents should be counted in the household, but their income should <i>not</i> count.</p>	<p>Revised for clarity</p> <p>Revised for clarity</p>
		<p>2. Second, it begins with "when the applicant is not a taxpayer," which seems to exclude individuals who expect to be claimed as a dependent but <i>also</i> file their own taxes. It should have language to include dependent exceptions from sections B(1) & (2) who may actually file their own taxes.</p> <p>3. The words "siblings" and "parents" are undefined, though they have very specific definitions in 42 C.F.R. § 435.603(b). Those words should be defined.</p> <p>4. It fails to specify that "children" refers only to children under the age of 19 (or 21 for full time students, if the state so chooses). Without that reference, the exceptions could include adult children.</p> <p>Section B(5). Pregnant women: This rule is correct, but it fails to account for how the state will count pregnant women for the purposes of determining household size for <i>other</i> members of her family. In those cases, the state has the option to count her as 1, 2, or the mother + the total expected babies. This should be specified.</p>	<p>This concern is addressed in the introductory sentence of subsection (C).</p> <p>Revised for clarity</p> <p>Revised for clarity</p>
		<p>Section C. MAGI-based Household Income: This is roughly parallel to 42 C.F.R. § 435.603(d).</p> <p>Section C(1): For specificity, it may be good to add "the [MAGI-based] income of an individual..." Otherwise, this roughly parallels 42 C.F.R. § 435.603(d)(2).</p> <p>Section C(2): To more closely parallel the federal regulation and avoid potential confusion, this section should read: "The income of a tax dependent [other than the tax filer's spouse or biological, adopted or stepchild] who is included in the MAGI income group of the tax[filer]...is not counted [included in the household income of the taxfiler] whether or not..."</p>	
12		<p>R9-22-1421</p> <p>Section A. Insert "...excess [MAGI-based] income...from the [MAGI-based] household income."</p>	<p>Clarified title of rule. Income determinations for all persons under this article are based on MAGI methodologies. Therefore it is not necessary to repeat it every time the word "income" is used.</p>

Notices of Final Rulemaking

13		<p>R9-22-1422</p> <p>This appears to be the methodology under the traditional Medicaid rules. This rule seems to parallel 42 C.F.R § 603(h)(3). While there is flexibility in this process, there does not appear to be much connection to tax-based MAGI income or deductions.</p>	<p>This rule outlines methodology for determining income as of a point in time. It is not intended to include detail on specific types of income and treatment.</p>
14		<p>R9-22-1423</p> <p>In general in this and the next two sections, the Institute has concerns about how deduction and adjustments to income that often are not known until the end of the tax year will be handled.</p> <p>Section A: This section concerns lump sum payments but some of the examples are not counted as income under the MAGI calculation such as Veterans' Benefits and child support as explained in response to Section R9-22-1420.</p>	<p>Clarified rule and struck veterans benefits and child support arrearages, as these were only examples.</p>
15		<p>R9-22-1424</p> <p>Section B(1). This is apparently a run-on sentence that currently makes no sense.</p>	<p>Clarified rule.</p>
16		<p>R9-22-1427</p> <p>Section A(2). The rule does not explain what 106% refers to. Is it a MAGI converted eligibility threshold?</p> <p>Section B(1). The cross references to (B)(3)(a) and (b) seem incorrect as there are no subsections B(3)(a) or (b). Perhaps AHCCCS means (B)(1)(c)(i) and (ii).</p> <p>Section B(1)(c). The reference to "increased" earned income does not mesh with 42 U.S.C. § 1396r-6(a), which specifically dropped the word "increased" in its definition of income (compare to §1396a(e)(1), which includes "increased.") If § 1396r-6 gets extended at the end of the year, the deletion of "increased" will be important in addressing the question of whether individuals who lose their eligibility due to the MAGI transition will be eligible for Transitional Medical Assistance ("TMA"). That is, their MAGI-based income may change even if their "earned income" does not.</p> <p>Section E(2). This refers to not being eligible under one of the other mandatory groups. It appears to conflict with 42 C.F.R. § 436.404 that directs the agency to allow an individual eligible for different groups to select which group to have his/her eligibility determined.</p>	<p>Yes, the rule explains that the countable income cannot exceed 106% of the FPL for those who qualify under MAGI, as defined under R9-22-1420(B).</p> <p>Updated references.</p> <p>The language in 1396 r-6a is no longer applicable after December 31, 2013. See 42 USC 1396a(e)(1)(B).</p> <p>42 USC 1396a(a)(10)(A)(i)(VIII) and 42 CFR 435.119(b)(4) requires that the individual not be eligible under any of the other mandatory groups.</p>

Notices of Final Rulemaking

17		<p>R9-31-1402</p> <p>Section B. The rule provides that a premium is imposed if the household income is greater than 100% of the federal poverty level. A household with MAGI up to 133% (138% with the 5% income disregarded) is eligible for Medicaid and no premiums are allowed for these persons. In addition, a younger child is eligible for AHCCCS when the household income exceeds 138%. <i>See</i> R9-22-1427C. Effective January 1, 2014, 42 C.F.R. § 447.55 sets forth the premiums that are allowed for different categories of eligible persons whose incomes exceed 150%. In addition, 42 C.F.R. § 447.56 sets forth the limitations on premiums and cost sharing. All the income and premium amounts need to be revised to reflect the increased Medicaid eligibility and the ACA regulations on cost-sharing cited above. Finally, state law only allows for premiums for children whose household income exceeds 150%, A.R.S. 36-2982(E), but even that law appears to conflict with the heightened income eligibility for Medicaid children as noted above</p> <p>In several sections, the proposed rule refers to Article 9, Chapter 22 and our comments above apply here as well.</p> <p>Finally, the federal Children's Health Insurance Program Reauthorization Act, 42 U.S.C. §1397cc(e)(3), provides for a 30 day grace period for non-payment of a premium and at least a 7 day notice at the end of the grace period that failure to pay the premium will result in termination from the program. We could not find that provision in the rules.</p>	<p>Clarified rule.</p> <p>Our responses to comments from Chapter 22 apply here as well.</p> <p>The grace period concern is addressed in the current R9-31-1418.</p>
----	--	---	---

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters are applicable.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The rule does not require a permit.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

The rule implements 42 USC 1396a as amended by the Affordable Care Act, and federal regulations at 42 CFR Part 435, which, in relevant part, mandates certain changes to encompass more eligible persons (e.g., foster children up to age 26 and children with household income between 100% and 133% of the federal poverty level) and implements optional changes to provide coverage to more persons (childless adults). In addition, that federal law and the implementing regulations mandate certain changes to the methods for determining eligibility. These rules follow those federal directives and parameters.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:

The following incorporations have been updated in:

R9-22-305 - 42 CFR 435.403

R9-22-306 - 42 CFR 433.147

R9-22-1501 - 42 CFR 435.530

R9-22-1501 - 42 CFR 435.540

R9-22-1503 - 20 CFR 416.1160

R9-22-1503 - 20 CFR 416.1163(b)(1) and (2)

R9-22-1505 - 42 CFR 435.520, 42 CFR 435.530, or 42 CFR 435.540

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published

Notices of Final Rulemaking

in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ADMINISTRATION**

ARTICLE 3. GENERAL ELIGIBILITY REQUIREMENTS

Section

R9-22-301.	Reserved <u>General Eligibility Definitions</u>
R9-22-302.	Reserved <u>AHCCCS Eligibility Application</u>
R9-22-304.	<u>Verification of Eligibility Information</u>
R9-22-305.	<u>Eligibility Requirements</u>
R9-22-306.	<u>Administration, Administration's designee or Member Responsibilities</u>
R9-22-307.	<u>Approval or Denial of Eligibility</u>
R9-22-308.	<u>Reinstating Eligibility</u>
R9-22-309.	<u>Confidentiality and Safeguarding of Information</u>
R9-22-310.	<u>Ineligible Person</u>
R9-22-311.	<u>Assignment of Rights Under Operation of Law</u>
R9-22-312.	<u>Member Notices</u>
R9-22-313.	<u>Withdrawal of Application</u>
R9-22-314.	<u>Withdrawal from AHCCCS Medical Coverage</u>
R9-22-315.	<u>Notice of Adverse Action</u>
R9-22-316.	<u>Exemptions from Sponsor Deemed Income</u>
R9-22-317.	<u>Sponsor Deemed Income</u>

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR ~~FAMILIES AND INDIVIDUALS~~ HOUSEHOLDS

Section

R9-22-1401.	General Information
R9-22-1402.	Ineligible Person <u>Repeal</u>
R9-22-1403.	Agency Responsible for Determining Eligibility
R9-22-1404.	Assignment of Rights Under Operation of Law <u>Repeal</u>
R9-22-1405.	Confidentiality and Safeguarding of Information <u>Repeal</u>
R9-22-1406.	Application Process <u>Repeal</u>
R9-22-1407.	Deceased Applicants <u>Repeal</u>
R9-22-1408.	Applicant and Member Responsibility <u>Repeal</u>
R9-22-1409.	Withdrawal of Application <u>Repeal</u>
R9-22-1410.	Department Responsibilities <u>Repeal</u>
R9-22-1411.	Withdrawal from AHCCCS Medical Coverage <u>Repeal</u>
R9-22-1412.	Verification of Eligibility Information <u>Repeal</u>
R9-22-1413.	Time-frames, Approval, Discontinuance, or Denial <u>Reinstatement</u> of an Application
R9-22-1414.	Review of Eligibility <u>Repeal</u>
R9-22-1415.	Notice of Adverse Action <u>Repeal</u>
R9-22-1416.	Effective Date of Eligibility
R9-22-1417.	Social Security Number <u>Repeal</u>
R9-22-1418.	State Residency <u>Repeal</u>
R9-22-1419.	Citizenship and Immigrant Status <u>Repeal</u>
R9-22-1420.	Income Eligibility Criteria
R9-22-1421.	<u>MAGI based Income Eligibility</u>
R9-22-1422.	Methods for Calculating Monthly Income
R9-22-1423.	Calculations and Use of Methods Listed in R9-22-1422 Based on Frequency of Income
R9-22-1424.	Use of Methods Listed in R9-22-1423 Based on Type of Income
R9-22-1425.	Sponsor Deemed Income <u>Repeal</u>

Notices of Final Rulemaking

- R9-22-1426. ~~Exemptions from Sponsor Deemed Income Repeal~~
R9-22-1427. ~~Eligibility for a Family Repeal~~
R9-22-1427. ~~Eligibility Under MAGI~~
R9-22-1428. ~~Eligibility for a Person Not Eligible as a Family Repeal~~
R9-22-1429. Eligibility for a Newborn
R9-22-1430. ~~Extended Medical Coverage for a Pregnant Woman Repeal~~
R9-22-1431. Family Planning Services Extension Program (FPEP)
R9-22-1432. Young Adult Transitional Insurance
R9-22-1443. ~~Closing New Eligibility for Persons Not Covered under the State Plan Repeal~~

ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED

Section

- R9-22-1501. General Information
R9-22-1502. ~~General Eligibility Criteria Repeal~~
R9-22-1503. Financial Eligibility Criteria
R9-22-1505. Eligibility for Special Groups

ARTICLE 3. GENERAL ELIGIBILITY REQUIREMENTS

R9-22-301. ~~Reserved~~ General Eligibility Definitions

Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article, Article 14 and Article 15 have the following meanings unless the context explicitly requires another meaning:

“Applicant”, notwithstanding R9-22-101, means a person listed on an application for whom AHCCCS coverage is being sought.

“BHS” means the division of Behavioral Health Services within the Arizona Department of Health Services.

“CRS” means the program administered by the Administration or its designee that provides covered medical services and covered support services in accordance with A.R.S. 36-261.

“DCSS” means the Division of Child Support Services, which is the division within the Department that administers the Title IV-D program and includes a contract agent operating a child support enforcement program on behalf of the Department.

“FAA” means the Family Assistance Administration, the administration within the Department's Division of Benefits and Medical Eligibility with responsibility for providing cash and food stamp assistance to a member and for determining eligibility for AHCCCS medical coverage.

“Income” means combined earned and unearned income.

“Medical support” means to provide health care coverage in the form of health insurance or court-ordered payment for medical care.

“Member” means an applicant who has been determined to qualify for AHCCCS coverage by the Administration or its designee.

“Pre-enrollment process” means the process that provides an applicant the opportunity to choose an AHCCCS health plan before the determination of eligibility is completed.

“Resources” means real and personal property, including liquid assets.

“Sponsor” means an individual who signs the USCIS I-864 Affidavit of Support agreeing to support a non-citizen as a condition of the non-citizen's admission for permanent residence in the United States.

“Sponsor deemed income” means the unearned income deemed available to the applicant named on the USCIS I-864 Affidavit of Support.

“SVES” means the State Verification and Exchange System, a system through which the Department exchanges income and benefit information with the Internal Revenue Service, Social Security Administration, and State Wage and Unemployment Insurance Benefit data files.

“USCIS” means the United States Citizen and Immigration Services.

R9-22-302. ~~Reserved~~ AHCCCS Eligibility Application

Application Process

1. Right to apply. A person may apply for AHCCCS medical coverage by submitting an Administration-approved application to the Administration or its designee, an FAA office, or one of the following outstation locations:
 - a. A BHS site;
 - b. A Federally Qualified Health Center or disproportionate share hospital under 42 U.S.C. 1396r-4; or
 - c. Any other site, including a hospital, approved by the Administration or its designee.
2. Application. To initiate the application process, the Administration or its designee will accept an application from the applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Internal Revenue Service (IRS) Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant by submitting a written or online application under 42

Notices of Final Rulemaking

CFR 435.907.

- a. A phone or written application must contain at least the following to be submitted to the Administration or its designee:
 - i. Applicant's legible name.
 - ii. Address or location where the applicant can be reached.
 - iii. Signature of the person submitting the application.
 - iv. Date the application was signed.
 - v. The Administration or its designee shall require that a third party witness the signing and attest by signing the application if the individual signing the application signs with a mark.
- b. An online application must be completed in full in order to be submitted to the Administration or its designee.
3. Incomplete application. If the application is incomplete, the Administration or its designee shall do at least one of the following:
 - a. Contact an applicant or an applicant's representative by telephone or electronic medium to obtain the missing information required for an eligibility determination;
 - b. Mail a request for additional information to an applicant or an applicant's representative, allowing 10 days from the date of the request to provide the required additional information; or
 - c. Meet with the applicant, representative, or household member.
4. Date of application. The date of application is the date application is received by the Administration or its designee either on-line or at a location listed in subsection (1).
5. Complete application form. The Administration or its designee shall consider an application complete when all questions are answered. The same person as listed under subsection (2) is the person that must sign the completed application. The application shall be witnessed and signed by a third party if the individual signing the application signs with a mark.
6. Assistance with application. The Administration or its designee shall allow a person of the applicant's choice to accompany, assist, and represent the applicant in the application process.

R9-22-304. Verification of Eligibility Information

- A.** Except as provided in subsection (E), if information provided by or on behalf of an applicant or member on an application, renewal form or otherwise does not conflict with information obtained by the agency through an electronic data match, the Administration or its designee shall determine or renew eligibility based on such information.
- B.** The Administration or its designee shall not require an applicant, member, or representative to provide additional verification unless the verification cannot be obtained electronically or the verification obtained electronically conflicts with information provided by or on behalf of the applicant or member.
- C.** If information provided by or on behalf of an applicant or member does conflict with information obtained through an electronic data match, the applicant or member shall provide the Administration or its designee with information or documentation necessary to verify eligibility, including evidence originating from an agency, organization, or an individual with actual knowledge of the information.
- D.** Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both meet or both exceed the applicable income limit.
- E.** The Administration or its designee shall not accept the applicant's or member's statement by itself as verification of:
 1. SSN;
 2. Qualified alien status, except as described under 42 USC 1320b-7(d)(4)(A); or
 3. Citizenship, except as described under 42 USC 1396a(ee)(1).
- F.** The Administration or its designee shall give an applicant or member at least 10 days from the date of a written or electronic request for information to provide required verification. The Administration or its designee may deny the application or discontinue eligibility if an applicant or a member does not provide the required information timely.

R9-22-305. Eligibility Requirements

As a condition of eligibility, the Administration or its designee must require applicants, and members to do the following:

1. Take all necessary steps to obtain any annuities, pensions, retirement, disability benefits to which they are entitled, unless they can show good cause for not doing so.
2. Furnish a SSN under 42 CFR 435.910 and 435.920, or in the absence of an SSN, provide proof of a submitted application of SSN. The Administration or its designee will assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910 if an applicant cannot recall the applicant's SSN or has not been issued a SSN. An applicant is not required to furnish an SSN if the applicant is not able to legally obtain a SSN. The Administration or its designee shall determine eligibility notwithstanding the applicant's lack of a SSN, if the applicant is cooperating with the Administration or its designee to obtain a SSN and obtain a SSN prior to the next scheduled review of eligibility.
3. Provide proof of residency of Arizona. An applicant or a member is not eligible unless the applicant or member is a resident of Arizona under 42 CFR 435.403 effective October 1, 2012, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol

Arizona Administrative Register / Secretary of State
Notices of Final Rulemaking

- Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
4. A written declaration, signed under penalty of perjury, must be provided for each person for whom benefits are being sought stating whether the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is a qualified alien. The declaration must be provided by the individual for whom eligibility is being sought or an adult member of the individual's family or household.
 5. Each applicant who claims qualified alien status must provide either:
 - a. Alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or
 - b. Other documents that the Administration or its designee accepts as evidence of immigration status, such as:
 - i. a Form I-94 Departure Record issued by the USCIS,
 - ii. a Foreign Passport,
 - iii. a USCIS Parole Notice,
 - iv. a Victim of Trafficking Certification or Eligibility Letter issued by the US DHHS Office of Refugee Resettlement,
 - v. other documentation consistent with 42 CFR 435.406 or 435.407.
 - c. Sufficient information for the Administration or its designee to obtain electronic verification of immigration status from the USCIS.
 6. If a person for whom eligibility is being sought, states that they are an alien, that person is not required to comply with subsections (4) and (5); however, if they do not comply with those sections, and if they meet all other eligibility criteria, benefits will be limited to those necessary to treat an emergency medical condition.

R9-22-306. Administration, Administration's designee or Member Responsibilities

- A.** The Administration or its designee is responsible for the following:
1. The Administration or its designee shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants, unless:
 - a. The agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or
 - b. When there is an administrative or other emergency beyond the agency's control.
 2. If an applicant dies while an application is pending, the Administration or its designee shall complete an eligibility determination for the deceased applicant.
 3. The Administration or its designee shall complete an eligibility determination on an application filed on behalf of a deceased applicant.
 4. During the application process the Administration or its designee shall provide information to the applicant or member explaining the requirements to:
 - a. Cooperate with DCSS in establishing paternity and enforcing medical support, except in circumstances when good cause under 42 CFR 433.147 exists for not cooperating;
 - b. Establish good cause for not cooperating with DCSS in establishing paternity and enforcing medical support, when applicable;
 - c. Report a change listed under subsection (B)(3)(c) no later than 10 days from the date the applicant or member knows of the change;
 - d. Send to the Administration or its designee any medical support payments resulting from a court order;
 - e. Cooperate with the Administration or its designee's assignment of rights and securing payments received from any liable party for a member's medical care.
 5. Offer to help the applicant or member to complete the application form and to obtain the required verification;
 6. Provide the applicant or member with information explaining:
 - a. The eligibility and verification requirements for AHCCCS medical coverage;
 - b. The requirement that the applicant or member obtain and provide a SSN to the Administration or its designee;
 - c. How the Administration or its designee uses the SSN;
 7. Explain to the applicant or member the practice of exchange of eligibility and income information through the electronic service established by the Secretary;
 8. Explain to the applicant and member the right to appeal an adverse action under R9-22-315;
 9. Use any information provided by the member to complete data matches with potentially liable parties;
 10. Explain the eligibility review process;
 11. Explain the AHCCCS pre-enrollment process;
 12. Use the Systematic Alien Verification for Entitlements (SAVE) process to verify qualified alien status;
 13. Provide information regarding the penalties for perjury and fraud on the application;
 14. Review any verification items provided by the applicant or member and inform the member of any additional verification items and time-frames within which the applicant or member shall provide information to the Administration or its designee;

Notices of Final Rulemaking

15. Explain to the applicant or member the applicant's and member's responsibilities under subsection (B):
 16. Transfer the applicant's information to other insurance affordability programs as described under 42 CFR 435.1200(e) when the applicant does not qualify for Medicaid;
 17. Attain a written record of a collateral contact: such as a verbal statement from a representative of an agency or organization, or an individual with actual knowledge of the information;
 18. Complete a review of eligibility:
 - a. Any time there is a change in a member's circumstance that may affect eligibility.
 - b. For a member approved for the MED program under R9-22-1435 through R9-22-1440 before the end of the six-month eligibility period.
 - c. Of each member's continued eligibility for AHCCCS medical coverage once every 12 months;
 19. The Administration or its designee shall discontinue eligibility and notify the member of the discontinuance under R9-22-307 if the member:
 - a. Fails to comply with the review of eligibility.
 - b. Fails to comply under 42 CFR 433.148 with the requirements and conditions of eligibility under this Article regarding assignment of rights and cooperation of establishing paternity and obtaining medical support, or
 - c. Does not meet the eligibility requirements; and
 20. Redetermine eligibility for a person terminated from the SSI cash program.
 - a. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from the SSI cash program until a redetermination of eligibility is completed.
 - b. Coverage group screening. Before terminating a person from the SSI cash program, the Administration shall determine if the person is eligible for coverage as a person described in A.R.S. §§ 36-2901(6)(a)(i) through (vi) or 36-2934.
 - c. Eligibility decision.
 - i. If a person is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice informing the applicant that AHCCCS medical coverage is approved.
 - ii. If a person is ineligible, the Administration shall send a notice to deny AHCCCS medical coverage.
- B. Applicant and Member Responsibilities.**
1. An applicant or a member shall authorize the Administration or its designee to obtain verification for initial eligibility or continuation of eligibility.
 2. As a condition of eligibility, an applicant or a member shall:
 - a. Provide the Administration or its designee with complete and truthful information. The Administration or its designee may deny an application or discontinue eligibility if:
 - i. The applicant or member fails to provide information necessary for initial or continuing eligibility;
 - ii. The applicant or member fails to provide the Administration or its designee with written authorization or electronic authorization to permit the Administration or its designee to obtain necessary initial or continuing eligibility verification;
 - iii. The applicant or member fails to provide verification under R9-22-304 after the Administration or its designee made an effort to obtain the necessary verification but has not obtained the necessary information; or
 - iv. The applicant or member does not assist the Administration or its designee in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility;
 - b. Cooperate with the Division of Child Support Services (DCSS) in establishing paternity and enforcing medical support obligations when requested unless good cause exists for not cooperating under 42 CFR 433.147 as of October 1, 2012, which is incorporated by reference, on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments. The Administration or its designee shall not deny AHCCCS eligibility to an applicant who would otherwise be eligible, is a minor child, and whose parent or legal representative does not cooperate with the medical support requirements or first- and third-party liability requirements under Article 10 of this Chapter; and
 - c. Provide the information needed to pursue third party coverage for medical care, such as:
 - i. Name of policyholder.
 - ii. Policyholder's relationship to the applicant or member.
 - iii. Name and address of the insurance company, and
 - iv. Policy number.
 3. A member or an applicant shall:
 - a. Send to the Administration or its designee any medical support payments received while the member is eligible that result from a medical support order;
 - b. Cooperate with the Administration or its designee regarding any issues arising as a result of Eligibility Quality Control described under A.R.S. § 36-2903.01; and
 - c. Inform the Administration or its designee of the following changes within 10 days from the date the applicant or

Notices of Final Rulemaking

member knows of a change:

- i. In address;
- ii. In the household's composition;
- iii. In income;
- iv. In resources, when required under the Medical Expense Deduction (MED) program;
- v. In Arizona state residency;
- vi. In citizenship or immigrant status;
- vii. In first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs;
- viii. That may affect the member's or applicant's eligibility, including a change in a woman's pregnancy status;
- ix. Death;
- x. Change in marital status; or
- xi. Change in school attendance.

4. As a condition of eligibility, an applicant or a member shall cooperate with the assignment of rights as required by R9-22-311. If the applicant or member receives medical care and services for which a first or third party is or may be liable, the applicant or member shall cooperate with the Administration or its designee in assisting, identifying and providing information to assist the Administration or its designee in pursuing any first or third party who is or may be liable to pay for medical care and services.
5. A pregnant woman under A.R.S. § 36-2901(6)(a)(ii) is not required to provide the Administration or its designee with information regarding paternity or medical support from a father of a child born out of wedlock.

C. Administration or its designee responsibilities at Eligibility Renewal.

1. The Administration or its designee shall renew eligibility without requiring information from the individual if able to do so based on reliable information available to the agency, including through an electronic data match. If able to renew eligibility based on such information, the Administration or its designee shall send the member notice of:
 - a. The eligibility determination; and
 - b. The member's requirement to notify the Administration or its designee if any of the information contained in the renewal notice is inaccurate.
2. If unable to renew eligibility, the Administration or its designee shall:
 - a. Send a pre-populated renewal form listing the information needed to renew eligibility.
 - b. Give the member 30 days from the date of the renewal form to submit the signed renewal form and the information needed.
 - c. Send the member notice of the renewal decision under R9-22-312 or R9-22-1413(B) as applicable.

R9-22-307. Approval or Denial of Eligibility

A. Approval. If the applicant meets all the eligibility requirements and conditions of eligibility of this Article, the Administration or its designee shall approve the application and provide the applicant with an approval notice. The approval notice shall contain:

1. The name of each approved applicant.
2. The effective date of eligibility for each approved applicant.
3. The reason and the legal citations if a member is approved for only emergency medical services, and
4. The applicant's right to appeal the decision.

B. Denial. If an applicant fails to meet the eligibility requirements or conditions of eligibility of this Article, the Administration or its designee shall deny the application and provide the applicant with a denial notice. The denial notice shall contain:

1. The name of each ineligible applicant.
2. The specific reason why the applicant is ineligible.
3. The income and resource calculations for the applicant compared to the income or resource standards for eligibility when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard.
4. The legal citations supporting the reason for the ineligibility.
5. The location where the applicant can review the legal citations.
6. The date of the application being denied; and
7. applicant's right to appeal the decision and request a hearing.

R9-22-308. Reinstating Eligibility

The Administration or its designee shall reopen an application or reinstate eligibility of a member when any of the following conditions are met:

1. The denial or discontinuance of eligibility was due to an administrative error.
2. The discontinuance of eligibility was due to noncompliance with a condition of eligibility and the applicant or member complies prior to the effective date of the discontinuance.
3. The member informs the Administration or its designee of a change of circumstances prior to the effective date of the

Notices of Final Rulemaking

- discontinuance, that would allow for continued eligibility, or
4. Following a discontinuance, the member qualifies for continuation of medical coverage pending an appeal.

R9-22-309. Confidentiality and Safeguarding of Information

The Administration or its designee shall maintain the confidentiality of an applicant or member's records and limit the release of safeguarded information under R9-22-512 and 6 A.A.C. 12, Article 1. In the event of a conflict between R9-22-512 and 6 A.A.C. 12, Article 1, R9-22-512 prevails.

R9-22-310. Ineligible Person

A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution, or
2. Over age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except as allowed in 42 USC 1396d(h) or as allowed under the Administration's Section 1115 waiver.

R9-22-311. Assignment of Rights Under Operation of Law

By operation of law and under A.R.S. § 36-2903, a person determined eligible assigns rights to the system medical benefits to which the person is entitled.

R9-22-312. Member Notices

- A.** Contents of notice. The Administration or its designee shall issue a notice by mail, personal delivery, or electronic means when an action is taken regarding a person's eligibility or premiums. The notice shall contain the following information:
1. The date of the notice issued;
 2. A statement of the action being taken;
 3. The effective date of the action;
 4. The specific reason for the intended action;
 5. If eligibility is being discontinued due to income in excess of the income standards, the actual figures used in the eligibility determination and the amount by which the person exceeds income standards;
 6. If a premium is imposed or increased, the actual figures used in determining the premium amount;
 7. The specific law or regulation that supports the action, or a change in federal or state law that requires an action;
 8. An explanation of the member's rights to an appeal and continued benefits.
- B.** Advance notice of changes in eligibility or premiums. "Advance notice" means a notice that is issued to a person at least 10 days before the effective date of the change. Except as specified in subsection (C), advance notice shall be issued whenever the following adverse action is taken:
1. To discontinue or suspend or reduce eligibility or covered services; or
 2. To impose a premium or increase a person's premium.
- C.** The Administration or its designee shall issue a Notice of Adverse Action to a member no later than the effective date of action if:
1. The Administration or its designee receives a request to withdraw;
 2. A person provides information that requires termination of eligibility or an increase or imposition of the premium and the person signs a clear written statement waiving advance notice;
 3. A person cannot be located and mail sent to that person has been returned as undeliverable;
 4. A person has been admitted to a public institution where the person is ineligible under R9-22-310;
 5. A person has been approved for Medicaid or CHIP in another state; or
 6. The Administration or its designee has information that confirms the death of the person.

R9-22-313. Withdrawal of Application

- A.** An applicant may withdraw an application at any time before the Administration or its designee completes an eligibility determination by making an oral or written request for withdrawal to the Administration or its designee and stating the reason for withdrawal.
- B.** If an applicant orally requests withdrawal of the application, the Administration or its designee shall document the:
1. Date of the request.
 2. Name of the applicant for whom the withdrawal applies, and
 3. Reason for the withdrawal.
- C.** An applicant may withdraw an application in writing by:
1. Completing an Administration-approved voluntary withdrawal form; or
 2. Submitting a written, signed, and dated request to withdraw the application.
- D.** The effective date of the withdrawal is the date of the application.
- E.** If an applicant requests to withdraw an application, the Administration or its designee shall:
1. Deny the application, and
 2. Notify the applicant of the denial following the notice requirements under R9-22-307.

R9-22-314. Withdrawal from AHCCCS Medical Coverage

Notices of Final Rulemaking

- A. A member may withdraw from AHCCCS medical coverage at any time by giving oral or written notice of withdrawal to the Administration or its designee. The member or the member's legal or authorized representative shall provide the Administration or its designee with:
 - 1. The reason for the withdrawal.
 - 2. The date the notice is effective, and
 - 3. The name of the member for whom AHCCCS medical coverage is being withdrawn.
- B. If a notice of withdrawal does not identify specific members the Administration or its designee shall discontinue eligibility for any members that the person submitting the withdrawal has legal authority to act on behalf of.
- C. The Administration or its designee shall notify the member of the discontinuance as required by R9-22-312.

R9-22-315. Notice of Adverse Action

- A. Adverse actions. An applicant or member may appeal, as described under Chapter 34, by requesting a hearing from the Administration or its designee concerning any of the following adverse actions:
 - 1. Complete or partial denial of eligibility under R9-22-307 and R9-22-313(E);
 - 2. Suspension, termination, or reduction of AHCCCS medical coverage under R9-22-307, R9-22-312 and R9-22-314;
 - 3. Delay in the eligibility determination beyond the time-frames under this Article;
 - 4. The imposition of or increase in a premium or copayment; or
 - 5. The effective date of eligibility.
- B. Notice of Adverse Action. The Administration or its designee shall personally deliver or send, by mail, or electronic means a Notice of Adverse Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Adverse Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.
- C. Automatic change and hearing rights.
 - 1. An applicant or a member is not entitled to a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
 - 2. An applicant or a member is entitled to a hearing if a federal or state law requires an automatic change and the applicant or member timely files an appeal that alleges a misapplication of the facts to the law.

R9-22-316. Exemptions from Sponsor Deemed Income

- A. An applicant shall provide proof to the Administration or its designee when claiming an exemption from sponsor deemed income.
- B. The Administration or its designee shall grant an exemption from deeming a sponsor's income for a Lawful Permanent Resident applicant if the applicant:
 - 1. Adjusted immigration status to Lawful Permanent Resident from status as a refugee or asylee;
 - 2. Is the spouse or dependent child of the sponsor and lives with the sponsor;
 - 3. Is indigent as specified in subsection (C);
 - 4. Is a victim of domestic violence or extreme cruelty as specified in subsection (D); or
 - 5. Has acquired 40 qualified quarters of work credit based on earnings as specified in subsection (E).
- C. Exemption from sponsor deeming based on indigence.
 - 1. The Administration or its designee shall consider the applicant indigent and grant an exemption from sponsor deemed income for an applicant, for a period of 12 months beginning with the first month of eligibility if all the following are met:
 - a. An applicant is indigent if all of the following are met:
 - i. The applicant does not reside with the applicant's sponsor;
 - ii. The applicant does not receive free room and board; and
 - iii. The applicant's total gross income including monies received from the sponsor and the value of any vendor payments received for food, utilities, or shelter does not exceed 100% of the FPL for the size of the income group.
 - 2. The Administration or its designee shall send a notice under 8 U.S.C. 1631(e)(2) to the Attorney General's Office when approving an applicant who is exempt from sponsor deemed income due to indigence.
- D. The Administration or its designee shall grant an exemption from sponsor deemed income for an applicant who is a victim of domestic violence or extreme cruelty under 8 CFR 204.2 for a period of 12 months beginning with the first month of eligibility. The Administration or its designee shall redetermine the exemption status at each renewal.
 - 1. The Administration or its designee considers an applicant to be a victim of domestic violence or extreme cruelty when all of the following are met:
 - a. The applicant is the victim, the parent of a child victim, or the child of a parent victim;
 - b. The perpetrator of the domestic violence or extreme cruelty was the spouse or parent of the victim or other family member related by blood, marriage or adoption to the victim;
 - c. The perpetrator was residing in the same household as the victim when the abuse occurred;
 - d. The abuse occurred in the United States;
 - e. The applicant did not participate in the domestic violence or cruelty; and

Notices of Final Rulemaking

"Burial plot" means a space reserved in a cemetery, crypt, vault, or mausoleum for the remains of a deceased person.

"Caretaker relative" means a parent who maintains a family setting for a dependent child and who exercises responsibility for the day-to-day physical care, guidance, and support of that child.

Caretaker relative" means:

A parent of a dependent child with whom the child is living;

When the dependent child does not live with a parent or the parent in the home is incapacitated, another relative of the child by blood, adoption, or marriage in the home who assumes primary responsibility for the child's care;
or

A woman in her third trimester of pregnancy with no other dependent children.

"Cash assistance" means a program administered by the Department that provides assistance to needy families with dependent children under 42 U.S.C. 601 et seq.

~~"CRS" means the program within ADHS that provides covered medical services and covered support services in accordance with A.R.S. 36-261.~~

~~"DCSE" means the Division of Child Support Enforcement, which is the division within the Department that administers the Title IV-D program and includes a contract agent operating a child support enforcement program on behalf of the Department.~~

"Dependent child" means a child under the age of 18, or if age 18 is a full-time student in secondary school or equivalent vocational or technical training, if reasonably expected to complete such school or training before turning age 19.

~~"FAA" means the Family Assistance Administration, the administration within the Department's Division of Benefits and Medical Eligibility with responsibility for providing cash and food stamp assistance to a member and for determining eligibility for AHCCCS medical coverage.~~

~~"Homebound" means a person who is confined to home because of physical or mental incapacity.~~

~~"Income" means combined earned and unearned income.~~

~~"Indigent" means an applicant's total income, including sponsor deemed income actually received, is less than or equal to 100% of the federal poverty level for the size of the income group under R9-22-1425.~~

~~"Liquid assets" means those assets in the form of cash or other financial instruments, that are convertible to cash and include:~~

~~Savings accounts;~~

~~Checking accounts;~~

~~Stocks and bonds;~~

~~Mutual fund shares;~~

~~Promissory notes;~~

~~Cash value of insurance policies; and~~

~~Similar assets.~~

"MAGI – based income" means Modified Adjusted Gross Income as defined under 42 CFR 435.603(e).

"Medical expense deduction" or "MED" means the cost of the following expenses if incurred in the United States:

A medical service or supply that would be covered if provided to an AHCCCS member of any age under Articles 2 and 12 of this Chapter;

A medical service or supply that would be covered if provided to an Arizona Long-term Care System member under 9 A.A.C. 28, Articles 2 and 11;

Other necessary medical services provided by a licensed practitioner or physician;

Assistance with daily living if the assistance is documented in an individual plan of care by a nurse, social service worker, registered therapist, or dietitian under the supervision of a physician except when provided by the spouse of an applicant or the parent of a minor child;

Medical services provided in a licensed nursing home or in an alternative HCBS setting under R9-28-101;

Purchasing and maintaining an animal guide or service animal for the assistance of a member of the MED family unit under R9-22-1436; and

Health insurance premiums, deductibles, and coinsurance, if the insured is a member of the MED family unit.

~~"Medical support" means to provide health care coverage in the form of health insurance or court-ordered payment for medical care.~~

"Monthly income" means the gross countable income received or projected to be received during the month or the monthly equivalent.

"Monthly equivalent" means a monthly countable income amount established by averaging, prorating, or converting a person's income.

~~"Nonparent caretaker relative" means a person, other than a parent, who is related by blood, marriage, or lawful adoption to a dependent child and who:~~

~~Maintains a family setting for the dependent child, and~~

~~Exercises responsibility for the day-to-day physical care, guidance, and support of the dependent child.~~

Notices of Final Rulemaking

~~“Pre-enrollment process” means the process that provides an applicant the opportunity to choose an AHCCCS health plan before the determination of eligibility is completed.~~

~~“Resource” means real and personal property, including liquid assets.~~

~~“Spendthrift restriction” means a legal restriction on the use of a resource that prevents a payee or beneficiary from alienating the resource.~~

~~“Sponsor” means an individual who signs the USCIS I-864 Affidavit of Support agreeing to support a non-citizen as a condition of the non-citizen’s admission for permanent residence in the United States.~~

~~“Sponsor deemed income” means the unearned income for an applicant named on the USCIS I-864 Affidavit of Support who is applying for AHCCCS medical coverage.~~

~~“SVES” means the State Verification and Exchange System, a system through which the Department exchanges income and benefit information with the Internal Revenue Service, Social Security Administration, and State Wage and Unemployment Insurance Benefit data files.~~

~~“Tax dependent” is described under 42 CFR 435.4.~~

~~“Taxpayer” means a person who expects to file a tax return, and does not expect to be claimed as a tax dependent by another person.~~

~~“Title IV-D” means Title IV-D of the Social Security Act, 42 U.S.C. 651-669, the statutes establishing the child support enforcement and paternity program.~~

~~“Title IV-E” means Title IV-E of the Social Security Act 42 U.S.C. 670-679, the statutes establishing the foster care and adoption assistance programs.~~

~~“USCIS” means the United States Citizen and Immigration Services.~~

R9-22-1402. Ineligible Person Repeal

A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution, or
2. Age 21 through age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except if allowed under the Administration’s Section 1115 waiver.

R9-22-1403. Agency Responsible for Determining Eligibility

The ~~Department~~ Administration or its designee shall determine eligibility under the provisions of this Article. The ~~Department~~ Administration or its designee shall not discriminate against an applicant or member because of race, color, creed, religion, ancestry, national origin, age, sex, or physical or mental disability.

R9-22-1404. Assignment of Rights Under Operation of Law Repeal

~~By operation of law and under A.R.S. § 36-2903, a person determined eligible assigns rights to the system and the county all types of medical benefits to which the person is entitled.~~

R9-22-1405. Confidentiality and Safeguarding of Information Repeal

~~The Administration and Department shall maintain the confidentiality of an applicant or member’s records and limit the release of safeguarded information under R9-22-512 and 6 A.A.C. 12, Article 1. In the event of a conflict between R9-22-512 and 6 A.A.C. 12, Article 1, R9-22-512 prevails.~~

R9-22-1406. Application Process Repeal

A. ~~Right to apply. A person may apply for AHCCCS medical coverage by submitting an Administration-approved written application to the Administration, an FAA office, or one of the following outstation locations:~~

1. ~~A BHS site;~~
2. ~~A facility contracted with CRS Administration;~~
3. ~~A Baby Arizona approved provider’s office, if the applicant is a pregnant woman;~~
4. ~~A Federally Qualified Health Center or disproportionate share hospital under 42 U.S.C. 1396r-4; or~~
5. ~~Any other site, including a hospital, approved by the Department or the Administration.~~

B. ~~Written application. To initiate the application process, any person may apply by submitting a written application under 42 CFR 435.907 with the appropriate signatures to one of the sites listed in subsection (A).~~

1. ~~A written application is one that contains the:~~
 - a. ~~Applicant’s legible name;~~
 - b. ~~Address or location where the applicant can be reached;~~
 - c. ~~Signature of the person listed in subsection (D)(2) or (D)(3);~~
 - d. ~~Date the application was signed.~~
2. ~~The Administration or Administration’s designee shall require that a third party witness the signing and attest by signing the application if the individual signing the application signs with a mark.~~
3. ~~The Administration or Administration’s designee shall accept an application for a person who is incapacitated and whose name and address are unknown.~~

C. ~~Date of application. The date of application is the date a written application is received by the Administration or its designee at a location listed in subsection (A).~~

Notices of Final Rulemaking

~~D.~~ Complete application form-

1. The Administration shall consider an application complete when:
 - a. All questions are answered; and
 - b. All necessary verification is provided by an applicant or an applicant's representative.
2. The Administration or Administration's designee shall not approve an application unless the applicant's legal representative, if one exists, signs the declarations on the application relating to the applicant's eligibility, under penalty of perjury-
3. If there is no legal representative, or the legal representative is incapacitated, one of the following shall sign the declarations on the application relating to the applicant's eligibility, under penalty of perjury:
 - a. The applicant, if age 18 or older;
 - b. The applicant, if less than 18 years old and married or not living with a parent;
 - c. The applicant's spouse if the applicant and spouse are not legally separated;
 - d. An adult who lives with an applicant, if the applicant is less than 18 years old or age 18 and a student;
 - e. One of the unmarried partners if living together with a child in common, if the child is the applicant;
 - f. Another party, if the applicant is incapacitated and no one listed in subsections (D)(3)(a) through (c) is available to sign the application on the applicant's behalf. The Administration shall require incapacity to be verified by written documentation signed by a licensed physician or by one of the following:
 - i. A physician assistant;
 - ii. A nurse practitioner, or
 - iii. A registered nurse under the direction of a licensed physician; or
 - g. A person authorized verbally in the presence of an employee of the Administration or the Administration's designee or in writing, by a person listed in subsection (D)(2) or (D)(3)(a) through (c), to represent the applicant in the application process. The authorized representative may sign the declaration on the application relating to the applicant's eligibility, under penalty of perjury.
4. Unmarried adults not applying for a child in common shall each sign the application if using the same application form.
5. The application shall be witnessed and signed by a third party if the individual signing the application signs with a mark.
6. If the application is incomplete, the Administration or the Administration's designee shall do at least one of the following:
 - a. Contact an applicant or an applicant's representative by telephone or electronic medium to obtain the missing information required for an eligibility determination;
 - b. Mail a request for additional information to an applicant or an applicant's representative, allowing 10 days from the date of the request to provide the required additional information; or
 - c. Meet with the applicant, representative, or household member.

~~E.~~ Assistance with application. The Administration or Administration's designee shall allow a person of the applicant's choice to accompany, assist, and represent the applicant in the application process.

R9-22-1407. Deceased Applicants Repeal

- ~~A.~~** If an applicant dies while an application is pending, the Administration or Administration's designee shall complete an eligibility determination for all applicants listed on the application, including the deceased applicant.
- ~~B.~~** The Administration or Administration's designee shall complete an eligibility determination on an application filed on behalf of a deceased applicant, if the application is filed in the same month as the applicant's death.

R9-22-1408. Applicant and Member Responsibility Repeal

- ~~A.~~** An applicant and a member shall authorize the Department to obtain verification for initial eligibility or continuation of eligibility.
- ~~B.~~** As a condition of eligibility, an applicant or a member shall:
 1. Provide the Department with complete and truthful information. The Department may deny an application or discontinue eligibility if:
 - a. The applicant or member fails to provide information necessary for initial or continuing eligibility;
 - b. The applicant or member fails to provide the Department with written authorization to permit the Department to obtain necessary initial or continuing eligibility verification;
 - c. The applicant or member fails to provide verification under R9-22-1412 after the Department made an effort to obtain the necessary verification but has not obtained the necessary information; or
 - d. The applicant or member does not assist the Department in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility;
 2. Cooperate with the Division of Child Support Enforcement (DCSE) in establishing paternity and enforcing medical support obligations when requested unless good cause exists for not cooperating under 42 CFR 433.147 as of October 1, 2006, which is incorporated by reference, on file with the Administration, and available from the U.S. Government

Notices of Final Rulemaking

Printing Office, Mail Stop: IDCC, 732 N. Capitol St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments. The Department shall not deny AHCCCS eligibility to an applicant who would otherwise be eligible, is a minor child, and whose parent or legal representative does not cooperate with the medical support requirements under subsection (E) or first- and third-party liability requirements under Article 10 of this Chapter; and

3. Provide the following information concerning third-party coverage for medical care:

- a. Name of policyholder;
- b. Policyholder's relationship to the applicant or member;
- c. SSN of the policy holder;
- d. Name and address of the insurance company, and
- e. Policy number.

C. A member or an applicant shall:

- 1. Send to the Department any medical support payments received while the member is eligible that result from a medical support order;
- 2. Cooperate with the Administration or Administration's designee regarding any issues arising as a result of Eligibility Quality Control described under A.R.S. § 36-2903.01; and
- 3. Inform the Department of the following changes within 10 days from the date the applicant or member knows of a change:
 - a. In address;
 - b. In the household's composition;
 - c. In income;
 - d. In resources, when required under R9-22-1438 for the Medical Expense Deduction (MED) program;
 - e. In Arizona state residency;
 - f. In citizenship or immigrant status;
 - g. In first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs; or
 - h. That may affect the member's or applicant's eligibility, including a change in a woman's pregnancy status.

D. As a condition of eligibility, an applicant or a member shall apply for other benefits as required under 42 CFR 435.608 as of October 1, 2006, which is incorporated by reference, on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

E. As a condition of eligibility, an applicant or a member shall cooperate with the assignment of rights under R9-22-1404. If the applicant or member receives medical care and services for which a first or third party is or may be liable, the applicant or member shall cooperate with the Department and the Administration in identifying and providing information to assist the Department and the Administration in pursuing any first or third party who is or may be liable to pay for medical care and services.

F. As a condition of eligibility of a child whose parent, legal representative, or other legally responsible adult applies for AHCCCS medical coverage on behalf of the child, the individual who applies for the child shall cooperate with the Department to establish paternity and obtain medical support or other payments as provided in A.R.S. § 46-292(C). However, a pregnant woman under A.R.S. § 36-2901(6)(a)(ii) is not required to provide the Department with information regarding paternity or medical support from a father of a child born out of wedlock.

R9-22-1409. Withdrawal of Application Repeal

A. An applicant may withdraw an application at any time before the Department completes an eligibility determination by making an oral or written request for withdrawal to the Department and stating the reason for withdrawal.

B. If an applicant orally requests withdrawal of the application, the Department shall document the:

- 1. Date of the request;
- 2. Name of the applicant for whom the withdrawal applies; and
- 3. Reason for the withdrawal.

C. An applicant may withdraw an application in writing by:

- 1. Completing a Department approved voluntary withdrawal form; or
- 2. Submitting a written, signed, and dated request to withdraw the application.

D. The effective date of the withdrawal is the date of the application.

E. If an applicant requests to withdraw an application, the Department shall:

- 1. Deny the application; and
- 2. Notify the applicant of the denial following the notice requirements under R9-22-1413.

R9-22-1410. Department Responsibilities Repeal

A. The Department shall provide during the application process to the applicant or member information explaining the requirements to:

Notices of Final Rulemaking

- ~~1. Cooperate with DCSE in establishing paternity and enforcing medical support, except in circumstances when good cause under 42 CFR 433.147 exists for not cooperating;~~
- ~~2. If applicable, establish good cause for not cooperating with DCSE in establishing paternity and enforcing medical support;~~
- ~~3. Report a change listed in R9-22-1408(C)(3) no later than 10 days from the date the applicant or member knows of the change;~~
- ~~4. Send to the Department any medical support payments received through a Title IV-D court order; and~~
- ~~5. Cooperate with the Department's and Administration's assignment of rights and securing payments received from any liable party for a member's medical care.~~

B. At initial application or eligibility review a Department representative shall:

- ~~1. Offer to help the applicant or member to complete the application form and to obtain required verification;~~
- ~~2. Provide the applicant or member with information explaining:~~
 - ~~a. The eligibility and verification requirements for AHCCCS medical coverage;~~
 - ~~b. The requirement that the applicant or member obtain and provide a SSN to the Department;~~
 - ~~c. How the Department uses the SSN;~~
 - ~~d. The Department's practice of exchanging eligibility and income information through the State Verification and Exchange System (SVES);~~
 - ~~e. The applicant and member's right to appeal an adverse action under R9-22-1441;~~
 - ~~f. The assignment of rights under operation of law as provided in A.R.S. § 36-2903;~~
 - ~~g. That the Department will use any information provided by the member to complete data matches with potentially liable parties;~~
 - ~~h. The eligibility review process;~~
 - ~~i. The program coverage and the types of services available under each program;~~
 - ~~j. The AHCCCS pre-enrollment process;~~
 - ~~k. Availability of continued AHCCCS medical coverage under R9-22-1427;~~
 - ~~l. That the Department will use the Systematic Alien Verification for Entitlements (SAVE) process to verify eligible alien status; and~~
 - ~~m. That the Department will help the applicant or member obtain necessary verification if the applicant or member asks for help;~~
- ~~3. Provide information regarding the penalties for perjury and fraud printed on the application;~~
- ~~4. Review any verification items provided by the applicant or member and inform the member of any additional verification items and time frames within which the applicant or member shall provide information to the Department;~~
- ~~5. Explain to the applicant or member the applicant's and member's responsibilities under R9-22-1408;~~
- ~~6. Provide information regarding all reporting requirements and explain to the applicant or member that the applicant or member may lose the earned income disregards under R9-22-1420 if the applicant or member fails to timely report earned income changes.~~

R9-22-1411. Withdrawal from AHCCCS Medical Coverage Repeal

- A.** ~~A member may withdraw from AHCCCS medical coverage at any time by giving oral or written notice of withdrawal to the Department. The member or the member's legal or authorized representative shall provide the Department with:~~
- ~~1. The reason for the withdrawal;~~
 - ~~2. The date the notice is effective; and~~
 - ~~3. The name of the member for whom AHCCCS medical coverage is being withdrawn.~~
- B.** ~~The Department shall discontinue eligibility for AHCCCS medical coverage for all family members if the notice of withdrawal does not identify a specific person.~~
- C.** ~~The Department shall notify the member of the discontinuance as required by R9-22-1415.~~

R9-22-1412. Verification of Eligibility Information Repeal

- A.** ~~An applicant or a member has the primary responsibility to provide the Department with information necessary to verify eligibility and complete the determination of eligibility at the time of initial application, when a change in circumstances occurs that may affect eligibility, or at the eligibility review under R9-22-1414. With the exception of subsection (B), the applicant or member shall use the following types of documents, in the following order, to verify information:~~
- ~~1. First, hard copy verification: written evidence originating from an agency, organization, or an individual with actual knowledge of the information;~~
 - ~~2. Second, a written record of a collateral contact: a verbal statement from a representative of an agency or organization, or an individual with actual knowledge of the information; and~~
 - ~~3. Third, the applicant's or member's written statement, to be used only if:~~
 - ~~a. Verification under subsections (A)(1) and (A)(2) is not available; and~~
 - ~~b. The statement is not inconsistent with other information.~~
- B.** ~~The Department shall not accept any form of verification other than hard copy verification for:~~

Notices of Final Rulemaking

1. SSN;
 2. Legal alien status;
 3. Proof of alien sponsor under R9-22-1425, if applicable;
 4. Relationship, when questionable; and
 5. Citizenship, when questionable.
- C.** The Department shall only accept hard copy verification or a collateral contact for verification of pregnancy and amounts billed for the care of a dependent child or incapacitated adult.
- D.** The Department shall provide an applicant or member at least 10 days from the date of a written request for information to provide required verification. The Department may deny the application or discontinue eligibility if an applicant or a member does not provide the required information timely.

R9-22-1413. Time-frames, ~~Approval, Discontinuance, or Denial~~ Reinstatement of an Application

- A.** ~~Application processing time.~~ The Department ~~Administration or its designee~~ shall complete an eligibility determination under ~~R9-22-306(A)(1) 42 CFR 435.911~~ within 45 days after the application date under R9-22-1406 unless:
1. The applicant is pregnant. The ~~Department Administration or its designee~~ shall complete an eligibility determination for a pregnant woman within 20 days after the application date unless additional information is required to determine eligibility; or
 2. The applicant is in a hospital as an inpatient at the time of application. Within seven days of the ~~Department's Administration or its designee's~~ receipt of a signed application the ~~Department Administration or its designee~~ shall complete an eligibility determination if the ~~Department Administration or its designee~~ does not need additional information or verification to determine eligibility.
- B.** ~~Approval.~~ If the applicant meets all the eligibility requirements and conditions of eligibility of this Article, the Department shall approve the application and provide the applicant with an approval notice. The approval notice shall contain:
1. ~~The name of each approved applicant;~~
 2. ~~The effective date of eligibility as defined in R9-22-1416 for each approved applicant;~~
 3. ~~The reason and the legal citations if a member is approved for only emergency medical services; and~~
 4. ~~The applicant's right to appeal the decision under R9-22-1441(A).~~
- C.** ~~Denial.~~ If an applicant fails to meet the eligibility requirements or conditions of eligibility of this Article, the Department shall deny the application and provide the applicant with a denial notice. The denial notice shall contain:
1. ~~The name of each ineligible applicant;~~
 2. ~~The specific reason why the applicant is ineligible;~~
 3. ~~The income and resource calculations for the applicant compared to the income or resource standards for eligibility when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard;~~
 4. ~~The legal citations supporting the reason for the ineligibility;~~
 5. ~~The location where the applicant can review the legal citations;~~
 6. ~~The date of the application being denied; and~~
 7. ~~The applicant's right to appeal the decision and request a hearing.~~
- D.** ~~The Department shall reopen an application or reinstate eligibility of a member when any of the following conditions are met:~~
1. ~~The denial or discontinuance of eligibility was due to an administrative error;~~
 2. ~~The discontinuance of eligibility was due to noncompliance with a condition of eligibility and the applicant or member complies prior to the effective date of the discontinuance;~~
 3. ~~The member informs the Department of a change of circumstances prior to the effective date of the discontinuance; that would allow for continued eligibility; or~~
 4. ~~Following a discontinuance the member requests and is eligible for continuation of medical coverage pending an appeal under R9-22-1441.~~
- B.** The Administration or its designee shall reopen or reinstate eligibility of an individual who is discontinued for failure to submit the renewal form or necessary information, without requiring a new application, if the individual submits the renewal form or necessary information within 90 days after the date of discontinuance.

R9-22-1414. Review of Eligibility ~~Repeal~~

- A.** Except as provided in subsection (B), the Department shall complete a review of each member's continued eligibility for AHCCCS medical coverage at least once every 12 months.
- B.** The Department shall complete a review of eligibility for a:
1. Pregnant woman determined eligible under R9-22-1428(2) following the termination of her pregnancy;
 2. Non-pregnant member approved only for Federal Emergency Services at least once in a six-month period;
 3. Member approved for the MED program under R9-22-1435 through R9-22-1440 before the end of the six-month eligibility period;
 4. Any time there is a change in a member's circumstance that may affect eligibility.
- C.** ~~If a member continues to meet all eligibility requirements and conditions of eligibility, the Department shall authorize~~

Notices of Final Rulemaking

continued eligibility and notify the member of continued eligibility. If the member continues to be eligible for Federal Emergency Services, the notice shall state that the continued eligibility is for Federal Emergency Services only.

- ~~D.~~ The Department shall discontinue eligibility and notify the member of the discontinuance under R9-22-1415 if the member:
- ~~1. Fails to comply with the review of eligibility;~~
 - ~~2. Fails to comply with the requirements and conditions of eligibility under this Article without good cause under 42 CFR 433.148; or~~
 - ~~3. Does not meet the eligibility requirements.~~

R9-22-1415. Notice of Adverse Action Repeal

- ~~A.~~ Notice requirement. If a member fails to meet an eligibility requirement or condition of eligibility under this Chapter, the Department shall provide the member a Notice of Adverse Action no later than 10 days before the effective date of the suspension, reduction, or discontinuance.
- ~~B.~~ The Department shall mail a Notice of Adverse Action to a member to discontinue eligibility no later than the effective date of action if the Department:
- ~~1. Receives a request to withdraw under R9-22-1411;~~
 - ~~2. Receives verification that the member is ineligible under R9-22-1402;~~
 - ~~3. Has documented information confirming the death of a member;~~
 - ~~4. Receives returned mail with no forwarding address from the post office and the member's whereabouts are unknown; or~~
 - ~~5. Verifies that the member has been approved for Medicaid by another state.~~

~~C.~~ The Department shall ensure that the Notice of Adverse Action contains:

 - ~~1. The name of each ineligible member;~~
 - ~~2. The specific reason why the member is ineligible;~~
 - ~~3. The income and resource calculations compared to the income or resource standards when the reason for the discontinuance is due to the member's income or resources exceeding the applicable standard;~~
 - ~~4. The legal citations supporting the reason for ineligibility;~~
 - ~~5. The location where the member can review the legal citations;~~
 - ~~6. The date the discontinuance is effective; and~~
 - ~~7. The member's appeal rights and right to continued medical coverage pending appeal under R9-22-1441.~~

R9-22-1416. Effective Date of Eligibility

- ~~A.~~ Except as provided in R9-22-303 and subsections (B), (C) and ~~(C)~~ (D), the effective date of eligibility is the first day of the month that the applicant files an application if the applicant is eligible that month, or the first day of the first eligible month following the application month except for:
- ~~1. The MED program under R9-22-1439, and~~
 - ~~2. Eligibility for a newborn under R9-22-1429.~~
- ~~B.~~ The effective date of eligibility for an applicant who moves into Arizona ~~during the month of application~~ is no sooner than the date Arizona residency is established.
- ~~C.~~ The effective date of eligibility for an inmate applying for medical coverage is the date the applicant no longer meets the definition of an inmate of a public institution.
- D. The effective date of eligibility for a newborn is no sooner than the date of birth.

R9-22-1417. Social Security Number Repeal

- ~~A.~~ As a condition of eligibility, an applicant or a member shall furnish a SSN under 42 CFR 435.910 and 435.920.
- ~~B.~~ A person who is not able to legally obtain a SSN is not required to furnish a SSN.
- ~~C.~~ The Department shall grant an applicant until the first review of eligibility to provide a SSN if the applicant is cooperating with the Department to obtain a SSN.
- ~~D.~~ If an applicant cannot recall the applicant's SSN or has not been issued a SSN, the Department shall assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910.

R9-22-1418. State Residency Repeal

An applicant or a member is not eligible unless the applicant or member is a resident of Arizona under 42 CFR 435.403 as of November 21, 1990, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments. The Department shall not consider an alien who does not have immigrant status under 8 U.S.C. 1101(a)(15) to be a resident.

R9-22-1419. Citizenship and Immigrant Status Repeal

- ~~A.~~ An applicant or a member is not eligible for full services under Article 2 of this Chapter, unless the applicant or member is a citizen of the United States or is a qualified alien under A.R.S. § 36-2903.03(B) or meets the requirements of A.R.S. § 36-2903.03(C).

Notices of Final Rulemaking

- ~~B.~~ The Department shall use the Systematic Alien Verification for Entitlements (SAVE) process to verify legal alien status.
- ~~C.~~ An applicant or member is eligible for emergency medical services under R9-22-217 if the applicant or member is either a qualified alien or noncitizen and:
- ~~1. Meets all other eligibility requirements except those in subsection (A), and~~
 - ~~2. Is eligible under A.R.S. § 36-2901(6)(a)(i), (ii), or (iii).~~

R9-22-1420. Income Eligibility Criteria

- A. Evaluation of income. In determining eligibility, the ~~Department~~ Administration or its designee shall evaluate the following types of income received by a person identified in subsection (B):
1. Earned income, including in-kind income, before any deductions. For purposes of this Section, in-kind income means room, board, or provision for other needs in exchange for work performed. The person identified in subsection (B) shall ensure that the provider of the in-kind income establishes and verifies the monetary value of the item provided. The provider may be, but is not limited to:
 - a. A landlord who provides all or a portion of rent or utilities in exchange for services;
 - b. A store owner who gives goods such as groceries, clothes, or furniture in exchange for services; or
 - c. An individual who trades goods such as a car, tools, trailer, building material, or gasoline in exchange for services;
 2. Self-employment income under R9-22-1424, including gross business receipts minus business expenses; and
 3. Unearned income, including deemed income under ~~R9-22-1425~~ R9-22-317 from the sponsor of a non-citizen applicant.
- B. ~~MAGI income group. A person whose income is counted.~~ The ~~Department~~ Administration or its designee shall include the following persons in the MAGI income group under Section 1902(a)(17) of the Act if living with the applicant unless the person is a SSI cash recipient:
- ~~1. Applicant;~~
 - ~~2. Applicant's parent if the applicant is an unmarried dependent child who is less than 18 years old;~~
 - ~~3. Applicant's spouse;~~
 - ~~4. A sponsor under 8 CFR 213a.1 of a person meeting the qualified alien requirements under A.R.S. § 36-2903.03 and the sponsor's spouse; and~~
 - ~~5. A non-parent caretaker relative and spouse, as allowed under R9-22-1427, and their unmarried minor children if applying as a family, including a dependent child living with a caretaker relative.~~
1. When the applicant is a taxpayer include:
 - a. The applicant.
 - b. Everyone the applicant expects to claim as a tax dependent for the current year, and
 - c. The applicant's spouse, when living with the applicant.
 2. Except as provided in subsection (B)(3), when the applicant expects to be claimed as a tax dependent for the current year include:
 - a. The taxpayer claiming the applicant.
 - b. Everyone else the taxpayer expects to claim as a tax dependent.
 - c. The taxpayer's spouse when living with the taxpayer, and
 - d. The applicant's spouse, when living with the applicant.
 3. When any of the following apply, determine the persons whose income is included as described in subsection (4)(a) or (4)(b) based on the applicant's age:
 - a. The applicant expects to be claimed as a tax dependent by someone other than a spouse or natural, adopted or step-parent;
 - b. The applicant is under age 19, expects to be claimed as a tax dependent by a natural, adopted or step-parent, lives with more than one such parent and the parents do not expect to file a joint tax return; or
 - c. The applicant is under age 19 and expects to be claimed as a tax dependent by a non-custodial parent.
 4. When the applicant is not a taxpayer, does not expect to be claimed as a tax dependent and is:
 - a. Under age 19. Include the income of the applicant and when living with the applicant, the applicant's:
 - i. Spouse;
 - ii. Natural, adopted and step-children;
 - iii. Natural, adopted and step-parents;
 - iv. Natural, adopted and step-siblings; and
 - b. Age 19 or older. Include the income of the applicant and when living with the applicant, the applicant's:
 - i. Spouse;
 - ii. Natural, adopted and step-children under age 19.
 5. When the applicant is a pregnant woman, the Administration or its designee shall also include the number of expected babies only for the pregnant woman's income group.
 6. When the taxpayer cannot reasonably establish that a person is the taxpayer's tax dependent, inclusion of the person in the taxpayer's MAGI income group is determined as provided in subsection (B)(4).

Notices of Final Rulemaking

- C.** ~~Income exclusions. The Department shall not count the following income:~~
- ~~1. Agent Orange settlement fund payments;~~
 - ~~2. AmeriCorps Network Program benefits;~~
 - ~~3. Burial benefits dispersed solely for burial expenses;~~
 - ~~4. Cash contributions from agencies or organizations other than the Department or the Administration if the contributions are not intended to cover the following items:~~
 - ~~a. Food;~~
 - ~~b. Rent or mortgage payments for shelter;~~
 - ~~c. Utilities;~~
 - ~~d. Household supplies such as bedding, towels, laundry, cleaning, and paper supplies;~~
 - ~~e. Public transportation fares for personal use;~~
 - ~~f. Basic clothing or diapers; or~~
 - ~~g. Personal care and hygiene items, such as soap, toothpaste, shaving cream, and deodorant;~~
 - ~~5. Disaster assistance provided under the Federal Disaster Relief Act, disaster assistance organizations, or comparable assistance provided by state or local governments;~~
 - ~~6. Educational grants or scholarships funded by the United States Department of Education or from a Veterans Education assistance program or the Bureau of Indian Affairs student assistance program;~~
 - ~~7. Energy assistance that is provided:~~
 - ~~a. Either in cash or in kind by a government agency or municipal utility, or~~
 - ~~b. In kind by a private nonprofit organization;~~
 - ~~8. Earnings from high school on-the-job training programs;~~
 - ~~9. Earned income of a dependent child who is a student enrolled and attending school at least half-time as defined by the institution;~~
 - ~~10. Fair Labor Standard Act supplemental payment;~~
 - ~~11. Food stamp benefits;~~
 - ~~12. Foster care maintenance payments intended for a child who is not included in the family or Medical Expense Deduction (MED) unit;~~
 - ~~13. Funds set aside in an Individual Development Account under A.A.C. R6-12-404;~~
 - ~~14. Governmental rent and housing subsidies;~~
 - ~~15. Income tax refunds, including any earned income tax credit;~~
 - ~~16. Loans from a private person or a commercial or educational institution if there is a written agreement for repayment of the loan;~~
 - ~~17. Nonrecurring cash gifts that do not exceed \$30 per person in any calendar quarter;~~
 - ~~18. Payments made from a fund established by the Susan Walker v. Bayer Corporation class action lawsuit or the Ricky Ray Hemophilia Relief Fund Act of 1998;~~
 - ~~19. Radiation exposure compensation payments;~~
 - ~~20. Reimbursement for work-related expenses that do not exceed the actual expense amount;~~
 - ~~21. Reimbursement for Job Opportunities and Basic Skills (JOBS) Program training-related expenses;~~
 - ~~22. Reparation and restitution payments under Section 1902(r) of the Act;~~
 - ~~23. SSI designated account and interest earned on the account;~~
 - ~~24. Temporary Assistance for Needy Families (TANF) or SSI cash assistance payment;~~
 - ~~25. Vendor payment made by an organization or person who is not a member of the family or MED unit, to a third party to cover family expenses;~~
 - ~~26. Volunteers In Service To America (VISTA) income that does not exceed the state or federal minimum wage;~~
 - ~~27. Vocational rehabilitation program payments made as reimbursement for training-related expenses, subsistence and maintenance allowances, and incentive payments that are not intended as wages;~~
 - ~~28. Women, Infants, and Children (WIC) benefits; or~~
 - ~~29. Any other income specifically excluded under 20 CFR 416 Appendix to Subpart K, as of June 6, 1997, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.~~
- D.** ~~Special income provision for child support. The Administration or Administration's designee shall consider child support to be income of the child for whom the support is intended and count the child support income received after deducting \$50 per child receiving child support income from the monthly amount.~~
- E.** ~~Determining income for a month:~~
- ~~1. Calculating monthly income. The Administration or Administration's designee shall calculate monthly income under R9-22-1421 through R9-22-1426;~~
 - ~~2. The Administration or Administration's designee shall deduct the applicable disregards and deductions to which a person is entitled for the month.~~

Notices of Final Rulemaking

F. Earned income disregards.

1. ~~General. The Department shall apply the earned income disregards to each employed person's gross earnings.~~
2. ~~Disregards. The Department shall apply the following method to calculate the amount of the countable earned income under subsection (A):~~
 - a. ~~Subtract a \$90 cost of employment (COE) allowance from the gross amount of earned income for each person whose earned income is counted;~~
 - b. ~~Subtract an amount billed for the care of each dependent child or incapacitated adult member who is the responsibility of the person whose income is counted, if the care is for the purpose of allowing the person to work. If more than one person in the household is responsible for and billed for the care of a dependent child the disregard may be split between the wage earners to the benefit of the family, but shall not exceed the maximum disregards as follows:~~
 - i. ~~A maximum of \$200 for each child under age two and \$175 for each other dependent for a wage earner employed full-time (86 or more hours per month); and~~
 - ii. ~~A maximum of \$100 for each child under age two, and \$88 for each other dependent for a wage earner employed part-time (less than 86 hours a month).~~
3. ~~Loss of disregards. The Department shall not apply the earned income disregards if the member fails to report to the Department a change in earned income within 10 days from the date the change becomes known to the member. The change report to the Department shall be postmarked no later than the 10th day from the date the change becomes known.~~

A person whose income is counted. The Administration or its designee shall count the MAGI-based income of all members of an applicant's MAGI income group with the following exceptions:

1. The income of an individual who is included in the MAGI income group of his or her natural, adoptive or step parent and is not expected to be required to file a tax return for the year in which eligibility for Medicaid is being determined, is not counted whether or not the individual files a tax return.
2. The income of a tax dependent other than the taxpayer's spouse or biological, adopted or stepchild who is not expected to be required to file a tax return for the year in which eligibility for Medicaid is being determined is not counted when the tax dependent is included in the taxpayer's MAGI income group, whether or not the tax dependent files a tax return.

R9-22-1421. MAGI based Income Eligibility

- ~~**A.** A person is eligible under this Article unless the person's monthly income exceeds the appropriate Federal Poverty Level (FPL) listed in R9-22-1427 and R9-22-1428. A person is eligible under R9-22-1437 unless the person's income during the period defined in R9-22-1437(C) exceeds the FPL under R9-22-1437(B).~~
- ~~**B.** The Administration or Administration's designee shall consider the following factors when determining the income period to use to determine monthly income:~~
 1. ~~Type of income;~~
 2. ~~Frequency of income;~~
 3. ~~If source of income is new or terminated, or~~
 4. ~~Income fluctuation~~
- ~~**C.** Definitions:~~
 1. ~~"Monthly income" means the gross countable income received or projected to be received during the month or the monthly equivalent.~~
 2. ~~"Monthly equivalent" means a monthly countable income amount established by averaging, prorating, or converting a person's income.~~
- ~~**A.** In determining eligibility, if an individual would otherwise be ineligible under this Article due to excess income, the Administration or its designee shall subtract an amount equivalent to five percentage points of the Federal Poverty Level (FPL) from the household income.~~
- ~~**B.** A person is eligible under this Article when:~~
 1. ~~Subject to subsection (A), the monthly household income does not exceed the appropriate FPL;~~
 2. ~~If ineligible under (B)(1), the household income determined in accordance with 26 CFR 1.36B-1(e) is below 100 percent FPL; or~~
 3. ~~For eligibility under R9-22-1437, the person's income during the period defined in R9-22-1437(C) does not exceed the FPL under R9-22-1437(B).~~
- ~~**C.** The Administration or its designee shall consider the following factors when determining the income period to use to determine monthly income:~~
 1. ~~Type of income.~~
 2. ~~Frequency of income.~~
 3. ~~If source of income is new or terminated, or~~
 4. ~~Income fluctuation.~~

Notices of Final Rulemaking

R9-22-1422. Methods for Calculating Monthly Income

- A. Projecting income.**
1. Description. Projecting income is a method of determining the amount of income that a person will receive.
 2. Calculation. The ~~Department~~ Administration or its designee shall project income by:
 - a. Converting income to a monthly equivalent,
 - b. Using unconverted income, or
 - c. Prorating income to determine a monthly equivalent.
 3. Exclusion. When calculating projected monthly income, the Administration or ~~Administration's~~ its designee shall exclude an unusual variation in income under R9-22-1424(E), except for a month in which the variation is anticipated to occur.
- B. Averaged income.**
1. Description. Averaging income proportionally distributes the person's income received on a regular basis.
 2. Calculation. To average income, the Administration or ~~Administration's~~ its designee shall add the amount of the income and divide by the total number of pay periods. If the amount of income received per pay period fluctuates, and the fluctuation is expected to continue, the Administration or its designee shall:
 - a. Use the averaged weekly or bi-weekly amounts to convert weekly or bi-weekly income to a monthly equivalent;
 - b. Use the averaged monthly or semi-monthly amounts to project monthly income; and
 - c. Use the averaged hours worked and multiply the average by the current rate of pay. If there is a change in the rate of pay, use the new rate of pay when calculating projected income under subsection (A).
- C. Prorated income.**
1. Description. Prorated income evenly distributes a person's income over the period the income is intended to cover to calculate a monthly equivalent.
 2. Calculation. To prorate income, the Administration or its designee shall divide the total amount of the person's income received during the period by the number of months that the income is intended to cover.
- D. Converted income.**
1. Description. Converted income is income received weekly or biweekly that is changed to a monthly equivalent.
 2. Calculation.
 - a. The Administration or its designee shall average the weekly or bi-weekly income amounts before converting to the monthly equivalent if the person's past income fluctuates and the fluctuation is expected to recur.
 - b. To convert income paid weekly to a monthly equivalent, the Administration or its designee shall multiply the weekly average by 4.3 weeks.
 - c. To convert income paid bi-weekly to a monthly equivalent, the Administration or its designee shall multiply the bi-weekly average by 2.15 weeks.
- E. Unconverted income.**
1. Description. Unconverted income is the actual amount of income received or projected to be received during a month.
 2. Calculation. The Administration or its designee shall sum the actual amount of income received or projected to be received during a month.

R9-22-1423. Calculations and Use of Methods Listed in R9-22-1422 Based on Frequency of Income

- A. Monthly income.** If otherwise countable income is received monthly or in a lump sum, the Administration or its designee shall use the unconverted method for calculating monthly income.
1. Lump sum means a nonrecurring payment that serves as a complete payment.
 2. Lump sum payments include but are not limited to: rebates or credits; inheritances; insurance settlements; and payments for prior months from such sources as Social Security, ~~Veterans Administration~~, Railroad Retirement, ~~child support arrearages~~, or other benefits.
 3. A lump sum payment may include a portion intended for the current month.
- B. Weekly income.** If income is received weekly, the Administration or its designee shall convert the income to a monthly equivalent under R9-22-1422(D).
- C. Bi-weekly income.** If income is received bi-weekly, the Administration or its designee shall convert the income to a monthly equivalent under R9-22-1422(D).
- D. Semi-monthly or daily income.** If income is received semi-monthly or daily, the Administration or its designee shall use the unconverted method for calculating monthly income under R9-22-1422(E).
- E. Bimonthly, quarterly, semi-annual, or annual income.** If income is received bimonthly, quarterly, semi-annually, or annually, the Administration or its designee shall prorate the income received or projected to be received under R9-22-1422(C).

R9-22-1424. Use of Methods Listed in R9-22-1423 Based on Type of Income

- A. New income.**
1. Description. New income is income received from a new source during the first calendar month that the income is received from the source.

Notices of Final Rulemaking

2. Calculating monthly income.
 - a. If a full month's income is received, the Administration or ~~Administration's~~ its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
 - b. If less than a full month's income is received, the Administration or ~~Administration's~~ its designee shall use the unconverted method to calculate the monthly income.
- B. Terminated income.
 1. ~~Description.~~ Terminated income is income received during the last calendar month ~~that income is received from a source~~ when no more income is expected to be received from ~~the~~ that source.
 2. Calculating monthly income.
 - a. If a full month's income is received, the Administration or ~~Administration's~~ its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
 - b. If less than a full month's income is received, the Administration or ~~Administration's~~ its designee shall use the unconverted method to calculate the monthly income.
- C. Break in income.
 1. Description. A break in income is a break in established frequency of income of one calendar month or more.
 2. Calculating monthly income.
 - a. If a full month's income is received, the Administration or ~~Administration's~~ its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
 - b. If less than a full month's income is received, the Administration or ~~Administration's~~ its designee shall use the unconverted method to calculate the monthly income.
- ~~D. Contract income.~~
 1. ~~Description. Contract income is income a person earns under a contract or other legal document that specifies a length of time the contract or legal document covers, the amount of income to be paid, and the frequency of payment.~~
 2. ~~Calculating monthly income.~~
 - a. ~~The Administration or designee shall calculate the monthly income based on the frequency of payment if income is paid more frequently than monthly.~~
 - b. ~~The Administration or designee shall prorate over the period of time specified by the contract if income is paid monthly or less frequently.~~
- D. Contract or regular seasonal income.
 1. Descriptions.
 - a. Contract income is income a person earns under a contract that specifies a length of time the contract covers, the amount of income to be paid, and the frequency of payment.
 - b. Regular seasonal income is income that fluctuates based on season or is only received during a certain season, and can reasonably be anticipated based on history or other verification.
 2. Calculating monthly income.
 - a. When the contract or regular seasonal income will not fluctuate over the 12-month period beginning with the month the application or renewal is submitted, the Administration or its designee shall use the appropriate income calculation method in R9-22-1423 for the frequency of receipt.
 - b. When the contract or regular seasonal income is anticipated to fluctuate over the 12-month period beginning with the month the application or renewal is submitted, the Administration or its designee shall calculate the monthly income as follows:
 - i. For a one-time contract that ends between the month the application or renewal is submitted and the end of the calendar year, divide the income that will be received from the application or renewal month through the end of the calendar year by the number of months in that period to get a monthly equivalent;
 - ii. For contracts that extend into the next calendar year, contract that are anticipated to be renewed and regular seasonal income, the Administration or its designee shall divide the income that will be received in the 12 month period beginning with the application or renewal month by 12 to get the monthly equivalent.
- E. Unusual variation in the amount of income.
 1. Description. Unusual variation is an amount of income that is different from the established amount received and is not projected to continue or recur.
 2. Calculating monthly income.
 - a. When calculating income for the month in which an unusual variation in income occurs, the Administration or its designee shall include the unusual variation in the income calculation.
 - b. When an unusual variation in income occurs during the month, the Administration or ~~Administration's~~ its designee shall use the converted method for calculating monthly income if income is received weekly or bi-weekly.
 - c. When projecting income for the months following the month in which the unusual variation occurs, the Administration or its designee shall exclude the unusual variation in income from the income calculation.
- F. Self-employment income.
 1. Description. Self-employment income is income a person earns from the person's own trade or business less allow-

Notices of Final Rulemaking

able expenses.

2. Calculating monthly income. The Administration or ~~Administration's~~ its designee shall ~~use the following methods in the following order: prorate the income under R9-22-1422.~~
 - a. ~~When the self-employed person filed a tax return for the prior year and the person states that the current income is the same, the Administration or Administration's designee shall prorate the income under R9-22-1422.~~
 - b. ~~When the self-employed person did not file a tax return for the prior year or states that the current income is not the same, the Administration or Administration's designee shall:~~
 - i. ~~Use the person's business ledger or other records to verify the current income received, less allowable expenses; and~~
 - ii. ~~Use the appropriate method described in R9-22-1423 to calculate the monthly income.~~
 - c. ~~When the self-employed person did not file a tax return or keep business records of the income received and expense incurred during the income period, the Administration or Administration's designee:~~
 - i. ~~Shall use the person's written statement to verify income received;~~
 - ii. ~~Shall not deduct incurred expenses from the income without hard-copy verification of the expense; and~~
 - iii. ~~Shall use the appropriate method described in R9-22-1423 to calculate the monthly income.~~

R9-22-1425. Sponsor Deemed Income Repeal

A. ~~The Administration or Administration's designee shall use income of a USCIS sponsor to determine eligibility for a non-citizen applicant, whether or not the income is available, to the non-citizen applicant unless exempt under R9-22-1426.~~

B. ~~Counting the income from a sponsor.~~

1. ~~This Section applies to non-citizens applicants who:~~
 - a. ~~Are Lawful Permanent Residents under 8 CFR 101.3;~~
 - b. ~~Applied for Lawful Permanent Resident Status on or after December 19, 1997;~~
 - c. ~~Are sponsored by an individual who signed a USCIS I-864 Affidavit of Support; and~~
 - d. ~~Are eligible for full AHCCCS medical coverage.~~
2. ~~Sponsor deemed income shall be considered the income of the non-citizen applicant only.~~
3. ~~The Administration shall not use the provisions of this Section and R9-22-1426 when:~~
 - a. ~~The applicant becomes a naturalized U.S. citizen;~~
 - b. ~~The applicant qualifies for an exemption listed in R9-22-1426; or~~
 - c. ~~The sponsor dies.~~

C. ~~Determining income from a sponsor.~~

1. ~~For an applicant who is exempt under R9-22-1426(C) and (D), only cash contributions actually received from the sponsor are countable income to the applicant.~~
2. ~~For an applicant to whom the sponsor's income is deemed, the Department shall exclude any cash contributions received from the sponsor.~~

D. ~~Calculation of income from a sponsor.~~

1. ~~The Department shall include the total gross income of the sponsor and the following individuals who live in the sponsor's household:~~
 - a. ~~The sponsor's spouse;~~
 - b. ~~The sponsor's dependent children, and~~
 - c. ~~The sponsor's spouse's dependent children;~~
2. ~~The Department shall subtract the total gross income from 100% of the FPL for the sponsor's family size; and~~
3. ~~The amount calculated under subsections (D)(1) and (D)(2) represents the remaining amount deemed to the applicant from the sponsor.~~

R9-22-1426. Exemptions from Sponsor Deemed Income Repeal

A. ~~An applicant shall provide proof to the Administration or designee when claiming an exemption from sponsor deemed income.~~

B. ~~The Administration or designee shall grant an exemption from using a sponsor's income for a Lawful Permanent Resident applicant if the applicant:~~

1. ~~Entered the U.S. or applied for a visa or adjustment of status before December 19, 1997;~~
2. ~~Adjusted immigration status to Lawful Permanent Resident from status as a refugee or asylee;~~
3. ~~Qualifies only for Federal Emergency Services;~~
4. ~~Has a sponsor who signed an Affidavit of Support other than the USCIS Form I-864;~~
5. ~~Is the spouse or child of the sponsor and lives with the sponsor;~~
6. ~~Is indigent as specified in subsection (C);~~
7. ~~Is a victim of domestic violence or extreme cruelty as specified in subsection (D); or~~
8. ~~Has acquired 40 qualified quarters of work credit based on earnings as specified in subsection (E).~~

C. ~~The Administration or designee shall grant an exemption from sponsor deemed income for indigent applicants for a period of 12 months beginning with the application month. The Administration or designee shall redetermine indigent sta-~~

Notices of Final Rulemaking

tus at each eligibility renewal.

1. An applicant is indigent if all of the following are met:
 - a. The applicant does not reside with the applicant's sponsor;
 - b. The applicant does not receive free room and board; and
 - c. The applicant's total gross income including monies received from the sponsor and the value of any vendor payments received for food, utilities, or shelter does not exceed 100% of the FPL.
 2. The Administration shall send a notice to the Department of Homeland Security when approving an applicant who is exempt from sponsor deemed income due to indigency.
- D.** The Administration shall grant an exemption from sponsor deemed income for an applicant who is a victim of domestic violence or extreme cruelty under 8 CFR 204.2 for a period of 12 months beginning with the application month. The Administration shall redetermine the exemption status at each renewal.
1. The Administration considers an applicant to be a victim of domestic violence or extreme cruelty when all of the following are met:
 - a. The applicant is the victim, the parent of a child victim, or the child of a parent victim;
 - b. The perpetrator of the domestic violence or extreme cruelty was the spouse or parent of the victim or other family member related by blood, marriage or adoption to the victim;
 - c. The perpetrator was residing in the same household as the victim when the abuse occurred;
 - d. The abuse occurred in the United States;
 - e. The applicant did not participate in the domestic violence or cruelty; and
 - f. The victim does not currently live with the perpetrator.
 2. The applicant shall provide proof that the applicant or the applicant's child is a victim of domestic violence or extreme cruelty by presenting one of the following:
 - a. USCIS form I-360 Petition for Amerasian, Widow, or Special Immigrant;
 - b. USCIS form I-797 USCIS approval of the I-360 petition;
 - c. Reports or affidavits concerning the domestic violence or cruelty from police, judges, or other court officials, medical personnel, school officials, clergy, social workers, counseling or mental health personnel, or other social service agency personnel;
 - d. Legal documentation, such as an order of protection against the perpetrator or an order convicting the perpetrator of committing an act of domestic violence or extreme cruelty that chronicles the existence of domestic violence or extreme cruelty;
 - e. Evidence that indicates that the applicant sought safe haven in a battered women's shelter or similar refuge because of the domestic violence or extreme cruelty against the applicant or the applicant's child; or
 - f. Photographs of the applicant or applicant's child showing visible injury.
- E.** The Administration shall grant an exemption from sponsor deemed income for an applicant who has reached 40 qualifying quarters of work credit.
1. The Administration or Administration's designee shall not count quarters credited after January 1, 1997 that were earned while the applicant was receiving any federal means tested benefits.
 2. The Administration shall not count the 40 qualifying quarters of work credit unless the credited quarters are:
 - a. Quarters that the applicant worked;
 - b. Quarters worked by the applicant's spouse or deceased spouse during their marriage; or
 - c. Quarters worked by the applicant's parents when the applicant was under age 18.

R9-22-1427. Eligibility for a Family Repeal

- A.** A family unit with an eligible deprived dependent child is eligible for AHCCCS medical coverage when the requirements of this Section are met. A woman in her third trimester of pregnancy with no other dependent children is considered a family unit with a dependent child.
- B.** A family unit includes the following when living together:
1. A natural or adopted dependent child under age 18;
 2. A dependent child who is age 18 and:
 - a. A full-time student at a secondary school or attending a vocational or technical training school that includes shop practicum for at least 30 hours per week or does not include shop practicum and attendance is at least 25 hours per week; and
 - b. Reasonably expected to complete the education or training before age 19; and
 3. A natural or adoptive parent of a dependent child.
- C.** The Department shall include in the family unit, the spouse of the dependent child's parent if the spouse wants to apply for AHCCCS medical coverage. The Department shall include the spouse of the non-parent caretaker relative if:
1. The non-parent caretaker relative applies and is eligible; and
 2. The non-parent caretaker relative applies for the spouse.
- D.** The Department shall include in the family unit, a dependent child's non-parent caretaker relative if the non-parent caretaker relative wants to apply for AHCCCS medical coverage and:

Notices of Final Rulemaking

1. Provides the dependent child with:
 - a. Physical care;
 - b. Support;
 - c. Guidance; and
 - d. Control; and
 2. The parent of a dependent child:
 - a. Does not live in the non-parent caretaker relative's home;
 - b. Lives with the non-parent caretaker relative but is also a dependent child; or
 - c. Lives with the non-parent caretaker relative but cannot function as a parent due to physical or mental impairment.
- E.** The Department shall not include a SSI cash recipient in the family unit.
- F.** A child is considered a deprived dependent if deprived of parental support and care by:
1. Continued absence of a parent;
 2. Death of a parent;
 3. Disability of a parent, as determined by a healthcare practitioner;
 4. Unemployment or under employment of a parent in a two-parent assistance unit under subsection (I).
- G.** Continued absence of a parent:
1. Continued absence under subsection (F) is established:
 - a. When absence of the parent from the home either interrupts or terminates the parent's functioning as a provider of support, physical care, or guidance for the child;
 - b. When absence of the parent from the house for a known or indefinite duration precludes relying on the parent for the present support or care of the child; or
 - c. When the parent's absence from the home is for a period of 30 days or more and for any reason other than those listed in subsection (G)(2).
 2. The Department shall not consider the following to be continued absence:
 - a. The parent is voluntarily absent to visit friends or relatives, to seek employment or maintain a job, or to attend school or training if the parent in the home and the absent parent are not separated;
 - b. The parent is absent due to active military duty;
 - c. The parents live in separate dwellings and the dwellings are considered part of a single home; or
 - d. One parent is absent from the home in order to allow the remaining family members to qualify for medical assistance.
- H.** Disability of a parent, as determined by a healthcare practitioner:
1. Disability is established if the parent or applicant provides a medical statement from a healthcare practitioner that includes:
 - a. A diagnosis of the parent's medical condition;
 - b. A finding that the parent has a physical or mental condition that prevents the parent from working; and
 - c. An opinion concerning the duration of unemployability or a date for re-evaluation of unemployability.
 2. Disability is established without further medical verification if the parent or applicant provides evidence that:
 - a. The Social Security Administration (SSA) has determined that the parent is eligible for Retirement, Survivors, Disability Insurance (RSDI) benefits due to blindness or disability;
 - b. The SSA has determined that the parent is eligible for Supplemental Security Income (SSI) due to blindness or disability;
 - c. The Veteran's Administration has determined that the parent has a 100% disability;
 - d. The parent's healthcare practitioner has released the parent from the hospital and imposed work restrictions for a specified recuperation period;
 - e. The parent's employer or physician has required the parent to terminate employment due to the onset of a disability and the healthcare practitioner has specified a recuperation period;
 - f. The parent's healthcare practitioner has determined that the parent is capable of employment only in a sheltered workshop under 26 U.S.C. 151(c)(5)(B), for a specified period of time, and the parent is so employed; or
 - g. A prior certification of the parent's disability by a healthcare practitioner is in the applicant's case record as maintained by the Department and is still valid to cover the period in which assistance is requested and will be received.
- I.** Unemployment or under employment of a parent in a two-parent assistance unit:
1. A child is deprived if the primary wage earning parent is unemployed or underemployed and the two-parent assistance unit meets the following requirements:
 - a. The child's natural or adoptive mother and father both reside with the child, and
 - b. Neither parent meets the provisions of subsection (F)(3).
 2. "Underemployment" means the parent's earned income combined with the assistance unit's other countable income does not exceed the income standards provided in subsection (J).

Notices of Final Rulemaking

3. "Primary wage earner" means the parent in a two-parent assistance unit who earned the greater amount of income in the 24-month period immediately preceding the month in which an application for assistance is submitted.
- ~~J.~~ **J.** Income standard. A family unit is not eligible if the family unit's countable income exceeds 100 percent of the FPL adjusted annually for the family unit.
- ~~K.~~ **K.** Continued medical coverage. An eligible member of the family unit under this Section is entitled to continued AHCCCS coverage for up to 12 months if eligible under subsection (K)(3)(a) and up to four months if eligible under subsection (K)(3)(b) if the family unit's income exceeds 100 percent of the FPL and the following conditions are met:
 1. The family continues to include a dependent child;
 2. The family received AHCCCS medical coverage under this Section for three calendar months out of the most recent six months; and
 3. The loss of AHCCCS coverage under this Section is due to:
 - a. Increased earned income of the caretaker relative and the person is a member of the family unit in accordance with 42 U.S.C. 1396a(e)(1) and 42 U.S.C. 1396r-6; or
 - b. Increased spousal or child support and the family unit member meets requirements under 42 CFR 435.115(f).
- ~~L.~~ **L.** An applicant may be added to the continued medical coverage of a family unit, under subsection (K)(3)(a), if the applicant did not reside with the family unit at the time continued medical coverage under this Section was determined and the applicant is:
 1. The spouse or dependent child of the family unit receiving continued medical coverage, or
 2. The parent of a dependent child who is a member of the family unit receiving continued medical coverage.

R9-22-1427. Eligibility Under MAGI

- A.** Caretaker Relatives. An individual is eligible for AHCCCS medical coverage as a Caretaker Relative when the individual meets the following requirements:
 1. Is a caretaker relative as defined in R9-22-1401.
 2. The total countable income under R9-1420(B) does not exceed 106 percent of the FPL for the number of people in the MAGI income group.
- B.** Continued medical coverage.
 1. A caretaker relative eligible under subsection (A) and all dependent children eligible under subsection (D) in the caretaker relative's MAGI income group are entitled to continued AHCCCS coverage for up to 12 months if eligible under subsection (B)(1)(c)(i) and up to four months if eligible under subsection (B)(1)(c)(ii) if the MAGI income group's income exceeds the limit for the income group's size and the following conditions are met:
 - a. The caretaker relative still lives with a dependent child;
 - b. A caretaker relative in the income group received AHCCCS medical coverage under this Section for three calendar months out of the most recent six months; and
 - c. The loss of AHCCCS coverage under this Section is due to:
 - i. Increased earned income of a caretaker relative, or
 - ii. Increased spousal support.
 2. An applicant may be added to the continued medical coverage under subsection (B)(1), if the applicant did not reside in the household at the time continued medical coverage under this Section was determined and the applicant is:
 - a. The spouse or dependent child of a caretaker relative receiving continued medical coverage, or
 - b. The parent of a dependent child who is receiving continued medical coverage.
- C.** Pregnant Women. A pregnant woman is eligible for AHCCCS medical coverage when the total countable income under R9-22-1420(B) does not exceed 156 percent of the FPL for the number of people in the MAGI income group. A pregnant woman who applies for AHCCCS medical coverage during the pregnancy or postpartum period and is determined eligible, remains eligible throughout the postpartum period. The postpartum period begins the day the pregnancy terminates and ends the last day of the month in which the 60th day following pregnancy termination occurs.
- D.** Children. A child less than 19 years of age is eligible for AHCCCS medical coverage when the total countable income under R9-22-1420(B) does not exceed the following percentage of the FPL for the number of people in the MAGI income group:
 1. 147 percent for a child under one year of age.
 2. 141 percent for a child age one through five years of age, or
 3. 133 percent for all other persons.
- E.** Adults. An individual is eligible for AHCCCS medical coverage when the individual meets the following eligibility requirements:
 1. Is 19 years of age or older but less than 65 years of age;
 2. Is not pregnant;
 3. Is not eligible for AHCCCS Medical Coverage under any other coverage group listed in 42 U.S.C. 1396a(a)(10)(A)(i);
 4. Is not entitled to or enrolled for Medicare benefits under Part A or Part B;
 5. The total countable income under R9-22-1420(B) does not exceed 133 percent of the FPL for the number of people in

Notices of Final Rulemaking

the MAGI income group; and

6. When the individual is a caretaker relative, but has income exceeding the limit in subsection (A)(2), each child under age 19 living with the individual is receiving AHCCCS medical coverage or KidsCare, or is enrolled in minimum essential coverage as defined in 42 CFR 435.4.

R9-22-1428. Eligibility for a Person Not Eligible as a Family Repeal

~~Income standards. A person who is not approved in a family unit under R9-22-1427 but meets all the eligibility requirements in the Article is eligible for AHCCCS medical coverage if countable income does not exceed the following percentage of the FPL:~~

- ~~1. 150 percent for a pregnant woman;~~
- ~~2. 140 percent for a child under one year of age;~~
- ~~3. 133 percent for a child age one through five years of age; or~~
- ~~4. 100 percent for all other persons.~~

R9-22-1429. Eligibility for a Newborn

~~A child born to a mother eligible for and receiving medical coverage under this Article, Article 15 of the Chapter, or 9 A.A.C. 28, is automatically eligible for AHCCCS medical coverage for a period not to exceed 12 months if the child continuously lives with the mother in the state of Arizona. Automatic eligibility begins on the child's date of birth and ends with the last day of the month in which the child turns age one. The Department shall conduct an informal review when the child is six months old to ensure the child resides with the mother in Arizona.~~

R9-22-1430. Extended Medical Coverage for a Pregnant Woman Repeal

- ~~A. A pregnant woman who applies for and is determined eligible for AHCCCS medical coverage during the pregnancy remains eligible throughout the postpartum period.~~
- ~~B. The postpartum period begins the day the pregnancy terminates and ends the last day of the month in which the 60th day following pregnancy termination.~~

R9-22-1431. Family Planning Services Extension Program (FPEP)

- ~~A. A member who loses eligibility for AHCCCS medical coverage under R9-22-1430 due to the postpartum period ending and who has no other creditable coverage, as specified in 42 U.S.C. 300gg-3(c)(1), may receive up to 24 months of family planning services as provided in this Section and A.R.S. § 36-2907.04.~~
- ~~B. Review of eligibility.~~
 - ~~1. The Department Administration or its designee shall complete a review of each member's continued eligibility for FPEP at least once every 12 months.~~
 - ~~2. If a member continues to meet all eligibility requirements, the Department Administration or its designee shall authorize continued eligibility for the FPEP and notify the member of continued eligibility.~~
 - ~~3. The Department Administration or its designee shall discontinue eligibility and notify the member of the discontinuance under R9-22-1415 if the member:~~
 - ~~a. Has income that exceeds 150 156 percent of the FPL at the time of the 12-month review,~~
 - ~~b. Fails to comply with a review of eligibility under this subsection, or~~
 - ~~c. Meets any of the criteria under subsection (D).~~
- ~~C. Changes in the member's income after the initial or review eligibility determination shall not impact the member's eligibility during the following 12-month period.~~
- ~~D. The Administration or its designee shall deny or terminate a member from FPEP under this Section if the member:~~
 - ~~1. Voluntarily withdraws from the program;~~
 - ~~2. Has whereabouts that are unknown Cannot be located;~~
 - ~~3. Fails to provide information to the Administration or the Administration's its designee;~~
 - ~~4. Becomes an inmate of a public institution;~~
 - ~~5-4. Moves out-of-state;~~
 - ~~6-5. Has creditable coverage under 42 U.S.C. 300gg-3(c)(1);~~
 - ~~7-6. Fails to meet the documentation requirements for U.S. citizenship or legal alien status under A.R.S. § 36-2903.03;~~
 - ~~8-7. Becomes eligible under 9 A.A.C. 22, 9 A.A.C. 28, or 9 A.A.C. 31 for full services under Article 2 of this Chapter;~~
 - ~~9-8. Becomes sterile; or~~
 - ~~10-9. Dies.~~
- ~~E. The Administration or its designee shall not reinstate eligibility under this Section after the effective date of a discontinuance of eligibility unless the discontinuance is overturned on appeal or resulted from an administrative error.~~

R9-22-1432. Young Adult Transitional Insurance

~~A person under the age of 21 who was in the custody of the Department of Economic Security under A.R.S. Title 8, Chapter 5 or Chapter 10 on the person's 18th birthday is eligible for AHCCCS medical coverage under A.R.S. § 36-2901(6)(a)(iii). An individual is eligible for AHCCCS medical coverage when the individual meets all of the following eligibility requirements:~~

Notices of Final Rulemaking

1. Is 18 through 25 years of age;
2. Was in the custody of the Department of Economic Security under A.R.S. Title 8, Chapter 5 or Chapter 10 on the individual's 18th birthday;
3. Was eligible for and receiving AHCCCS Medical Coverage on the individual's 18th birthday; and
4. Is not eligible for AHCCCS Medical Coverage under 42 U.S.C. 1396a(a)(10)(A)(i)(I) - (VII).

R9-22-1443. ~~Closing New Eligibility for Persons Not Covered under the State Plan Repeal~~

- A.** ~~Definition. For purposes of this Section, "AHCCCS Care" refers to the eligibility category that includes individuals encompassed within the expanded definition of "eligible person" under A.R.S. § 36-2901.01 and R9-22-1428(4), but who do not meet eligibility criteria for an optional or mandatory Title XIX coverage group described in the Arizona State Plan for Medicaid.~~
- B.** ~~General Rule. Except as provided by this Section, neither the Department nor the Administration shall approve an individual for AHCCCS Care with an effective date of eligibility on or after July 8, 2011.~~
- C.** ~~Exception for pending applications. With respect to any applications that are pending as of July 8, 2011, the Department and the Administration shall approve any individual as eligible for AHCCCS Care who has met all eligibility requirements for AHCCCS Care during or after the month of application but prior to July 8, 2011, and has continuously met all eligibility requirements for AHCCCS Care since that date.~~
- D.** ~~Exception for children. The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:~~
1. ~~Was determined eligible under the Arizona State Plan for Medicaid based on being under the age of 19;~~
 2. ~~Would otherwise be discontinued due to reaching the age of 19 on or after July 8, 2011, under subsection (B) of this Section; and~~
 3. ~~Meets all eligibility requirements for AHCCCS Care on and after reaching age 19.~~
- E.** ~~Exception for KidsCare. The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:~~
1. ~~Was determined eligible under 9 A.A.C. 31 based on being under the age of 19;~~
 2. ~~Would otherwise be discontinued due to reaching the age of 19 on or after July 8, 2011, under subsection (B) of this Section; and~~
 3. ~~Meets all eligibility requirements for AHCCCS Care on and after reaching age 19.~~
- F.** ~~Exception for Young Adult Transitional Insurance (YATI). The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:~~
1. ~~Was determined eligible for YATI under R9-22-1432;~~
 2. ~~Would otherwise be discontinued due to reaching the age of 21 on or after July 8, 2011 under subsection (A) of this Section; and~~
 3. ~~Meets all eligibility requirements for AHCCCS Care on and after reaching age 21.~~
- G.** ~~Exception for certain SSI-MAO. The Department and the Administration shall approve as eligible for AHCCCS Care, on or after July 8, 2011, an individual who:~~
1. ~~Was determined eligible for AHCCCS Care; and~~
 2. ~~Whose eligibility category is changed on or after June 28, 2011, from AHCCCS Care to eligibility based on R9-22-1501(A)(1) (SSI Medical Assistance Only) because the individual, at the time of the change in eligibility category, is age 65 or over, under the age of 65 with Medicare coverage, or who has been determined by ADHS to have a Serious Mental Illness; but who~~
 3. ~~Subsequent to the change in eligibility category, is determined not to meet eligibility requirements under Article 15; but only if~~
 4. ~~The individual meets all eligibility requirements for AHCCCS Care on and after the date the individual is determined not to meet eligibility requirements under Article 15.~~
- H.** ~~Exception for redeterminations. This Section does not prohibit the redetermination of an individual as eligible for AHCCCS Care on or after July 8, 2011, if the individual was determined eligible for AHCCCS Care prior to July 8, 2011 and has remained continuously eligible for AHCCCS Care since July 8, 2011 or the date on which the individual was determined eligible for AHCCCS Care under subsections (C), (D), and (E) of this Section.~~
- I.** ~~Discontinuance for other reasons. Nothing in this Section prohibits or restricts the Department or the Administration from discontinuing AHCCCS Care for an individual who does not meet any other eligibility criteria set forth elsewhere in this Chapter including but not limited to discontinuance based on the individual's failure to verify eligibility information upon an application or redetermination.~~
- J.** ~~Review of anticipated expenditures. At least monthly, the Director shall review the most recent estimate of the anticipated expenditures for the remainder of the state fiscal year as compared to funds remaining in the appropriations made to the agency for the state fiscal year as well as any other known or reasonably anticipated sources of other funding. Based on that review the Director may, subject to approval by the Center for Medicare and Medicaid Services, re-open the AHCCCS Care program to new enrollment otherwise prohibited by this Section.~~
- K.** ~~At least 30 days prior to the effective date of any changes to eligibility for the AHCCCS Care program as described in this~~

Notices of Final Rulemaking

~~Section, public notice shall be provided via publication on the AHCCCS web site unless shorter notice is necessary to maintain a program that is reasonably anticipated to remain within available funding.~~

ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED

R9-22-1501. General Information

- A.** General. The Administration shall determine eligibility for AHCCCS medical coverage for the following applicants or members using the eligibility criteria and requirements in this Article and Article 3:
1. A person who is aged, blind, or disabled and does not receive SSI cash; and
 2. A person terminated from the SSI cash program under R9-22-1505.
- B.** Definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:
- “Aged” means a person who is 65 years of age or older as specified in 42 U.S.C. 1382c(a)(1)(A).
- “Blind” means a person who has been determined blind by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2) and 42 CFR 435.530 as of October 1, 2012, which are incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- “Disabled” means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E) and 42 CFR 435.540 as of October 1, 2012, which are incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- ~~**C.** Confidentiality. The Administration shall maintain the confidentiality of an applicant’s or member’s records and limit the release of safeguarded information under R9-22-512.~~
- ~~**D.** Application process:~~
- ~~1. A person may apply for AHCCCS medical coverage by submitting a signed application to any Administration office or outstation location under R9-22-1406.~~
 - ~~2. The provisions in R9-22-1406(B), (C), and (E) apply to this Section.~~
 - ~~3. The application date is the date a signed application is received at any Administration office or outstation location approved by the Director.~~
 - ~~4. An applicant who files an application may withdraw the application, either orally or in writing. If an applicant withdraws an application, the Administration shall send the applicant a denial notice under subsection (G).~~
 - ~~5. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants.~~
 - ~~6. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.~~
 - ~~7. The Administration shall complete an eligibility determination on an application filed on behalf of a deceased applicant, if the application is filed in the month of the applicant’s death.~~
- ~~**E.** Redetermination of eligibility for a person terminated from the SSI cash program:~~
- ~~1. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from the SSI cash program until a redetermination of eligibility under subsection (E)(2) is completed.~~
 - ~~2. Coverage group screening. The Administration shall screen a person under any coverage group under A.R.S. §§ 36-2901(6)(a)(i), (ii), (iii), (iv), and (v) and 36-2934.~~
 - ~~3. Eligibility decision:~~
 - ~~a. If a person is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice as under subsection (G) informing the applicant that AHCCCS medical coverage is approved.~~
 - ~~b. If a person is ineligible, the Administration shall send a notice as under subsection (G) to deny AHCCCS medical coverage.~~
- ~~**F.C.** Eligibility effective date.~~
- ~~1. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period described under R9-22-303.~~
 - ~~2. The effective date of eligibility for an applicant who moves into Arizona is no sooner than the date Arizona residency is established.~~
 - ~~3. The effective date of eligibility for an inmate applying for medical coverage is the date the applicant no longer meets the definition of an inmate of a public institution.~~
- ~~**G.** Notice for approval or denial. The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the intended action, and:~~
- ~~1. If approved, the notice shall contain the effective date of eligibility.~~

Notices of Final Rulemaking

2. If approved under FESP, the notice shall also contain:
 - a. The emergency services certification end date;
 - b. A statement detailing the reason for the denial of full services;
 - c. The legal authority supporting the decision;
 - d. Where the legal authority supporting the decision can be found;
 - e. An explanation of the right to request a hearing; and
 - f. The date by which a request for hearing shall be received by the Administration.
 3. If denied, the notice shall contain:
 - a. The effective date of the denial;
 - b. The reason for the denial, including specific financial calculations and the financial eligibility standard, if applicable;
 - c. Legal authority supporting the decision;
 - d. Where the legal authority supporting the decision can be found;
 - e. An explanation of the right to request a hearing; and
 - f. The date by which a request for hearing shall be received by the Administration.
- H. Reporting and verifying changes.**
1. An applicant or a member shall report to the Administration the following changes for the applicant or member, the applicant's or member's spouse, and the applicant or member's dependent children:
 - a. Change of address;
 - b. Change in the household's members;
 - c. Change in income;
 - d. Death;
 - e. Change in marital status;
 - f. Change in school attendance;
 - g. Change in Arizona state residency; and
 - h. Any other change that may affect the member's or applicant's eligibility.
 2. A member shall report to the Administration the following changes:
 - a. Admission to a penal institution;
 - b. Change in U.S. citizenship or immigrant status;
 - c. Receipt of a Social Security number; and
 - d. Change in first or third party liability that may contribute to the payment of all or a portion of the person's medical costs.
 3. A person other than a member or an applicant who reports a change to the Administration either orally or in writing shall include the:
 - a. Name of the affected applicant or member;
 - b. Description of the change;
 - c. Date the change occurred;
 - d. Name of the person reporting the change; and
 - e. Social Security or case number of the applicant or member, if known.
 4. An applicant or a member shall provide verification of changes if requested by the Administration.
 5. An applicant or a member shall report anticipated changes in eligibility to the Administration as soon as the person knows that the change will occur.
 6. An applicant or a member shall report an unanticipated change to the Administration within 10 days following the date the change occurred.
- I. Processing of changes and redeterminations.** If a member receives AHCCCS medical coverage under subsection (A), the Administration shall redetermine the member's eligibility at least once every 12 months or more frequently when changes occur that may affect eligibility.
- J. Actions that may result from a redetermination or change.** In processing a redetermination or change, the Administration shall determine whether there should be:
1. No change in eligibility;
 2. Discontinuance of eligibility if a condition of eligibility is no longer met; or
 3. A change in the program under which a person receives AHCCCS medical coverage.
- K. Notice of discontinuance.**
1. Contents of notice. The Administration shall issue a notice when it takes action to discontinue a member's eligibility. The notice shall contain the following information:
 - a. A statement of the action that is being taken;
 - b. The effective date of the action;
 - c. The reason for the discontinuance, including specific financial calculations and the financial eligibility standard if applicable;

Notices of Final Rulemaking

- d. The legal authority that supports the action proposed by the Administration;
 - e. Where the legal authority supporting the decision can be found;
 - f. An explanation of the right to request a hearing; and
 - g. The date by which a hearing request shall be received by the Administration and the right to continue medical coverage pending appeal.
2. Advance notice of changes in eligibility. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (K)(3), the Administration shall issue an advance notice when an adverse action is taken to suspend, reduce or discontinue eligibility.
3. Exceptions from advance notice. The Administration shall issue a notice to a member to discontinue eligibility no later than the effective date of the action if:
- a. The member provides to the Administration a clearly written statement, signed by that member, that:
 - i. Services are no longer wanted; or
 - ii. Gives information that requires a discontinuance or reduction of services and indicates that the member understands that this is the result of supplying the information;
 - b. The member provides information to the Administration that requires a discontinuance of eligibility and a member signs a written statement waiving advance notice;
 - c. The member cannot be located and mail sent to the member's last known address has been returned as undeliverable under 42 CFR 431.213(d) subject to reinstatement of discontinued eligibility;
 - d. The member has been admitted to a public institution where a member is ineligible for coverage;
 - e. The member has been approved for Medicaid in another state; or
 - f. The Administration receives information confirming the death of the member.
- L.** Request for hearing. An applicant or member may request a hearing under Chapter 34 for any of the following adverse actions:-
- 1. Complete or partial denial of eligibility;
 - 2. Discontinuance or reduction of AHCCCS medical coverage; or
 - 3. Delay in the eligibility determination beyond the time frames listed in R9-22-1501(D).
- M.** Assignment of rights. A person determined eligible assigns rights to all types of medical benefits to which the person is entitled under operation of law under A.R.S. § 36-2903.

R9-22-1502. General Eligibility Criteria Repeal

A. Social Security Number.

- 1. An applicant applying under R9-22-1501(A)(1) or (A)(2), or R9-22-1505(A) shall furnish a SSN or apply for one, as required under 42 CFR 435.910 and 435.920.
- 2. An applicant who meets all other eligibility criteria except the criteria in subsection (C) shall provide a SSN unless the applicant cannot legally obtain one.
- 3. If an applicant cannot recall or has not been issued a SSN, the Administration shall assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910.

B. State residency. A person is not eligible unless the person is a resident of Arizona under 42 CFR 435.403.

C. Citizenship and immigrant status.

- 1. An applicant or a member is not eligible for full services under Article 2 of this Chapter unless the applicant or member is a citizen of the United States or is a qualified alien under A.R.S. § 36-2903.03(B) or meets the requirements of A.R.S. § 36-2903.03(C).
- 2. An applicant or member is eligible for emergency medical services under R9-22-217 if the applicant or member is either a qualified alien or noncitizen and:
 - a. Meets all other eligibility requirements except those in subsection (A); and
 - b. Is eligible under A.R.S. § 36-2901(6)(a)(i), (ii), or (iii).

D. Applicant and member responsibility. As a condition of eligibility, an applicant and a member shall:

- 1. Authorize the Administration to obtain verification of information for initial or continued eligibility;
- 2. Give the Administration complete and truthful information. The Administration may deny an application or discontinue eligibility if:
 - a. The applicant or member fails to provide information necessary for initial or continuing eligibility;
 - b. The applicant or member fails to provide the Administration with written authorization to permit the Administration to obtain necessary verification;
 - c. The applicant or member fails to provide verification after the Administration had made an effort to obtain the necessary verification but has not obtained the necessary information; or
 - d. The applicant or member does not assist the Administration in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility;
- 3. Comply with the DCSE under 42 CFR 433.148 in establishing paternity and enforcing medical support obligations when requested. The Administration shall not deny AHCCCS eligibility to any applicant who would otherwise be eligible, is a minor child, and whose parent or legal representative does not cooperate with the medical support require-

Notices of Final Rulemaking

~~ments or first- and third-party liability under Article 10;~~

~~4. Provide information concerning third-party coverage for medical care; and~~

~~5. Take all necessary steps to obtain annuity, pension, retirement, and disability benefits for which the applicant or member may be entitled.~~

~~E. Inmate of a public institution. An inmate of a public institution is not eligible to AHCCCS coverage if federal financial participation (FFP) is not available.~~

~~F. Verification of eligibility information.~~

~~1. The applicant or member has the primary responsibility to provide the Administration with verification of all information necessary to complete the determination of eligibility.~~

~~2. The Administration shall provide an applicant or a member no less than 10 days following the date of written request for the information to provide required verification. If an applicant or member does not provide the required information timely, the Administration may deny the application or discontinue eligibility.~~

R9-22-1503. Financial Eligibility Criteria

A. General income eligibility. Except as provided under subsection (B) of this rule, the Administration or its designee shall count the identified income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the exceptions in subsection (B).

B. Exceptions.

1. In-kind support and maintenance under 42 U.S.C. 1382a(a)(2)(A) is excluded.

2. For a person living with a spouse, the Administration or its designee calculates net income for an eligible couple under ~~4220~~ CFR 416.1160 as of ~~June 15, 1999~~ April 1, 2013, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments, even if the spouse is not eligible for or applying for SSI or coverage under this Article.

3. In determining the net income of a married couple living with a child or the net income of a person who is not living with a spouse but living with a child, a child allocation is allowed as a deduction from the combined net income of the couple for each child regardless of whether the child is ineligible or eligible. For the purposes of this Section, a child means a person who is unmarried, natural or adopted, and under age 18 or under age 22 if a full-time student. Each child's allocation deduction is reduced by that child's income, including public income maintenance payments, using the methodology under 20 CFR 416.1163(b)(1) and (2) as of ~~June 15, 1999~~ April 1, 2013, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

4. In determining the income deemed available to an applicant who is a child from an ineligible parent or parents, an allocation for each eligible or ineligible child of the parent is allowed as a deduction from the parent's income under 20 CFR 416.1165(b). The child's allocation is reduced by that child's income, including public income maintenance payments.

5. In determining the income of a person who receives an annual Title II Cost of Living Allowance (COLA) increase, the COLA amount is disregarded ~~for the months of January through March, but is countable income effective in April to correspond with the FPL implementation date from January until the Administration applies the effective income limits under R9-22-1504 based on the FPL for the calendar year.~~

6. ~~Sponsor deemed income. The Administration shall use income of a USCIS sponsor to determine eligibility for a non-citizen applicant under R9-22-1425, whether or not the income is available, unless exempt under R9-22-1426.~~

R9-22-1505. Eligibility for Special Groups

A. The following are considered special groups:

1. A person meeting the requirements in A.R.S. § 36-2903.03 who:

a. Is aged, blind, or disabled under 42 CFR 435.520, 42 CFR 435.530, or 42 CFR 435.540 as of ~~October 1, 2004~~ October 1, 2012, which are incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

b. Received SSI cash or AHCCCS medical coverage under this subsection, or subsections (A)(2), (A)(3), or (A)(4) on or before August 21, 1996;

c. Was residing in the United States under color of law on or before August 21, 1996; and

d. Meets the requirements under this Article;

2. A disabled child (DC) under 42 U.S.C. 1396a(a)(10)(A)(i)(II). A disabled child is a child who:

a. Was receiving SSI cash benefits as a disabled child on August 22, 1996;

b. Lost SSI cash benefits effective July 1, 1997, or later, due to a disability determination under Section 211(d)(2)(B) of Subtitle B of P.L. 104-193;

c. Continues to meet the disability requirements for a child that were in effect on August 21, 1996; and

d. Meets the requirements under this Article;

Notices of Final Rulemaking

3. A disabled adult child (DAC), under 42 U.S.C. 1383c(c) who:
 - a. Was determined disabled by the Social Security Administration before attaining the age of 22 years,
 - b. Became entitled to or received an increase in child's insurance benefits under Title II of the Act on the basis of blindness or disability,
 - c. Was terminated from SSI cash benefits due to entitlement to or an increase in income under Title II of the Act,
 - d. Meets the requirements under this Article, and
 - e. Is 18 years of age or older;
 4. A disabled widow or widower (DWW) under 42 U.S.C. 1383c(b) and (d) who:
 - a. Is blind or disabled,
 - b. Is ineligible for Medicare Part A benefits,
 - c. Received SSI cash benefits the month before Title II of the Act benefit payments began, ~~and~~
 - d. Meets the requirements under this Article; ~~and~~
 - e. Is at least 50 years of age but under age 65; and
 - f. Is unmarried.
 5. Under 42 CFR 435.135, a person who:
 - a. Is aged, blind, or disabled;
 - b. Receives benefits under Title II of the Act;
 - c. Received SSI cash benefits in the past;
 - d. Received SSI cash benefits and Title II of the Social Security Act benefits concurrently for at least one month anytime after April 1977;
 - e. Became ineligible for SSI cash benefits while receiving SSI and benefits under Title II of the Act concurrently; and
 - f. Meets the requirements under this Article.
- B. Income for special groups.**
1. Except as provided in subsection (B)(2), income eligibility is determined using the income criteria in R9-22-1503(A).
 2. Exceptions to income for special groups.
 - a. For a person in the DAC coverage group under subsection (A)(3), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(c).
 - b. For a person in the DWW coverage group, under subsection (A)(4), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(b) and (d).
 - c. For an applicant or member in the coverage group under subsection (A)(5), the portion of the applicant's or member's Title II of the Social Security Act benefits attributed to cost-of-living adjustments received by the applicant since the effective date of SSI ineligibility is disregarded in determining income eligibility under 42 CFR 435.135.
- C. 100 percent FBR.** As a condition of eligibility for all special groups, countable income shall be equal to or less than 100 percent of the SSI FBR, as adjusted annually.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ARIZONA LONG-TERM CARE SYSTEM

[R14-03]

PREAMBLE

<u>1. Article, Part, or Section Affected (as applicable)</u>	<u>Rulemaking Action:</u>
R9-28-401	Amend
R9-28-401.01	Amend
R9-28-402	Repeal
R9-28-403	Repeal
R9-28-404	Repeal
R9-28-405	Repeal
R9-28-406	Amend
R9-28-407	Amend
R9-28-408	Amend
R9-28-409	Amend
R9-28-410	Amend

Notices of Final Rulemaking

R9-28-411	Amend
R9-28-413	Amend
R9-28-414	Amend
R9-28-415	Amend
R9-28-416	Amend
R9-28-418	Amend

2. Citations to the agency's statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. § 36-2932

Implementing statute: A.R.S. §§ 36-2932, 36-2933, 36-2934, 36-2934.01

Federal statute: 42 CFR Parts 431, 435, and 457

17144 Federal Register / Vol. 77, No. 57/Friday, March 23, 2012 / Rules and Regulations

Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted on March 30, 2010), and together referred to as the Affordable Care Act of 2010 (Affordable Care Act)

3. The effective date of the rule:

January 7, 2014. The agency requests an immediate effective date upon filing with the Secretary of State as specified in A.R.S. § 41-1032(A). The agency believes this rulemaking meets the immediate effective date requirements under the following subsections:

2. To avoid a violation of federal law or regulation or state law, if the need for an immediate effective date is not created due to the agency's delay or inaction.

3. To comply with deadlines in amendments to an agency's governing statute or federal programs, if the need for an immediate effective date is not created due to the agency's delay or inaction.

4. To provide a benefit to the public and a penalty is not associated with a violation of the rule.

These exceptions apply to this rulemaking since the Affordable Care Act requires the Administration to implement the higher federal poverty limit percentages and increase to the age limit for children in the foster care system. Therefore benefiting the public by providing coverage to more uninsured Arizona residents, The ACA requires this change to be effective January 1, 2014. The Administration will rely on federal law for the first seven days of January until the rule is effective, no penalties or effects are associated with the different effective date. The Administration had to wait for CMS to approve the eligibility FPL requirements which caused a delay in filing.

4. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 19 A.A.R. 3155, October 11, 2013

Notice of Proposed Rulemaking: 19 A.A.R. 3099, October 11, 2013

5. The agency's contact person who can answer questions about the rulemaking:

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson St.
Phoenix, AZ 85034
Telephone: (602) 417-4693
Fax: (602) 253-9115
E-mail: AHCCCSrules@azahcccs.gov
Web site: www.azahcccs.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Administration is promulgating rule amendments as result of the Affordable Care Act of 2010 and Arizona Laws 2013, First Special Session, Chapter 10 (House Bill 2010). The majority of the significant amendments exist within Chapter 22, acute care eligibility, but as a result of this review the Administration has reviewed the eligibility requirements existing within Chapter 28, ALTCS eligibility. The proposed changes are to ensure clarity, conciseness and the accuracy of the parallel eligibility requirements for the ALTCS program, such as, changes to processes for determining and redetermining eligibility including changes to accommodate on line applications and internet-based verification of income, citizenship and alien status, state residence, and other eligibility factors; and miscellaneous changes to clarify and conform to federal requirements.

Notices of Final Rulemaking

7. **A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**
A study was not referenced or relied upon when promulgating the proposed regulations.
8. **A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable.
9. **A summary of the economic, small business, and consumer impact:**
The proposed rule changes will not have a significant impact on funds used for the coverage of ALTCS Medicaid applicants.
10. **A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:**
No significant changes were made between the proposed rulemaking and the final rulemaking. Grammatical and technical changes have been made for clarity and as a result of the Governor's Regulatory Review Council's review.
11. **An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:**
Comments received as of the close of the comment period of November 12, 2013 were for the related rulemakings for Chapter 22 and Chapter 31. This rulemaking was not addressed in those comments, and no other comments were received about these rules.
12. **All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**
No other matters are applicable.
 - a. **Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**
The rule does not require a permit.
 - b. **Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**
This rule is not more stringent than federal law and has been made as required under federal authority: 42 CFR Parts 431, 435, and 457
17144 Federal Register / Vol. 77, No. 57 / Friday, March 23, 2012 / Rules and Regulations
Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted on March 30, 2010), and together referred to as the Affordable Care Act of 2010 (Affordable Care Act)
 - c. **Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**
No analysis was submitted.
13. **A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:**
R9-28-409 - 42 U.S.C. 1396p(c)(1)(A)
R9-28-409 - 42 U.S.C. 1396p(c)(1)(B)
R9-28-409 - 42 U.S.C. 1396p(c)(2)
R9-28-409 - 42 U.S.C. 1396p(c)(1)(E)
R9-28-409 - 42 U.S.C. 1396p(c)(2)(C)
14. **Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:**
Not applicable
15. **The full text of the rules follows:**

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 4. ELIGIBILITY AND ENROLLMENT

Notices of Final Rulemaking

Section

- R9-28-401. Eligibility and Enrollment-Related Definitions
- R9-28-401.01. General
- R9-28-402. ~~Categorical Requirements and Coverage Groups~~ Repeal
- R9-28-403. ~~State Residency~~ Repeal
- R9-28-404. ~~Citizenship and Qualified Alien Status~~ Repeal
- R9-28-405. ~~Social Security Enumeration~~ Repeal
- R9-28-406. ALTCS Living Arrangements
- R9-28-407. Resource Criteria for Eligibility
- R9-28-408. Income Criteria for Eligibility
- R9-28-409. Transfer of Assets
- R9-28-410. Community Spouse
- R9-28-411. Changes, Redeterminations, and Notices
- R9-28-413. Enrollment with an ~~EPD~~ Elderly and Physically Disabled (EPD) Program Contractor
- R9-28-414. Enrollment with the DD Program Contractor
- R9-28-415. Enrollment with a Tribal Program Contractor
- R9-28-416. Enrollment with the ~~FFS~~ Fee-for-Service (FFS) Program
- R9-28-418. Disenrollment

ARTICLE 4. ELIGIBILITY AND ENROLLMENT

R9-28-401. Eligibility and Enrollment-Related Definitions

Definitions. For purposes of this Article, the following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

“ALTCS acute care services” means services under 9 A.A.C. 22, Articles 2 and 12, that are provided to a person who meets ALTCS eligibility requirements in 9 A.A.C. 28, Article 4 and who:

Lives in an acute care living arrangement described in R9-28-406; or

Is not eligible for long-term care benefits, described in R9-28-409, due to a transfer under R9-28-409 without receiving fair consideration, or

Has refused institutionalized or HCBS services.

“Community spouse” means the husband or wife of an institutionalized person who has entered into a contract of marriage, recognized as valid by the state of Arizona, and who does not live in a medical institution.

“CSRD” means Community Spouse Resource Deduction, the amount of a married couple's resources that is excluded in the eligibility determination to prevent impoverishment of the community spouse as determined under R9-28-410.

“Fair consideration” means income, real or personal property, services, or support and maintenance equal to or exceeding the fair market value of the income or resources that were transferred.

“First continuous period of institutionalization” means the first period beginning on or after September 30, 1989 that the applicant was institutionalized for 30 consecutive days or more. To be considered institutionalized, the applicant must:

Have resided in a medical institution;

Have received paid formal Home and Community Based Services (HCBS);

Have received a combination of medical institutionalization and HCBS, or

Intend to receive HCBS and either:

Requests a Resource Assessment and is determined in need of institutional services by a Resource Assessment Medical Evaluation; or

Applies for ALTCS and is determined medically eligible by the Pre-Admission Screening (PAS).

“Institutionalized” means residing in a medical institution or receiving or expecting to receive HCBS that prevent the person from being placed in a medical institution as determined by the PAS.

“Medically eligible” means meeting the ALTCS medical eligibility criteria under Article 3 of this Chapter.

“MMMNA” means Minimum Monthly Maintenance Needs Allowance.

“Redetermination” means a periodic review of all eligibility factors for a recipient.

“Representative” means a person other than a spouse or a parent of a dependent child, who applies for ALTCS on behalf of another person.

“Share of costs” means the amount an ALTCS recipient is required to pay toward the cost of long term care services.

“Spouse” means a person legally married under Arizona law, a person eligible for Social Security benefits as the spouse of another person, or a person living with another person of the opposite sex and the couple represents themselves in the community as husband and wife.

R9-28-401.01. General

A. Application for ALTCS coverage.

1. The Administration shall provide a person the opportunity to apply for ALTCS ~~without delay~~ as described under

Notices of Final Rulemaking

Chapter 22, Article 3, unless specified otherwise in this Section.

2. ~~A person may be accompanied, assisted, or represented by another in the application process.~~
32. To apply for ALTCS, a person shall submit an application to an ALTCS eligibility office.
 - a. The application shall contain the applicant's name and address.
 - b. Before the application is approved, a person listed in A.A.C. ~~R9-22-1406(D)~~ R9-22-302(2) shall sign the application.
 - c. A witness shall also sign the application if an applicant signs the application with a mark.
 - d. The date of application is the date the application is received by the Administration or ~~Department~~ its designee as described in ~~R9-22-1406(C)~~ R9-22-302.
- 4.3. Except as provided in ~~R9-22-1501(D)(5)~~ R9-22-306, the Administration shall determine eligibility within 45 days from the date of application.
- 5.4. An applicant or representative who files an ALTCS application may withdraw the application for ALTCS coverage either orally or in writing to the ALTCS eligibility office where the application was filed. The Administration shall provide the applicant with a denial notice under subsection ~~(G)~~ (E).
- 6.5. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.
- 7.6. If a person dies before an application is filed, the Administration shall complete an eligibility determination on an application filed on behalf of the deceased applicant, if the application is filed in the month of the person's death.
- B. Conditions of ALTCS eligibility. Except for persons identified in subsection (C), the Administration shall approve a person for ALTCS if all conditions of eligibility ~~for one of the ALTCS coverage groups listed in R9-28-402(B)~~ are met. The conditions of eligibility are:
 1. ~~Categorical requirements under R9-28-402;~~
 - 2.1. Citizenship and alien status under Chapter 22, Article 3 R9-28-404;
 - 3.2. SSN under Chapter 22, Article 3 R9-28-405;
 - 4.3. Living arrangements under R9-28-406;
 - 5.4. Resources under R9-28-407;
 - 6.5. Income under R9-28-408;
 - 7.6. Transfers under R9-28-409;
 - 8.7. A legally authorized person shall assign rights to the Administration for medical support and for payment of medical care from any first- and third-parties ~~as described under R9-22-311, and shall cooperate by:~~
 - a. ~~Obtaining medical support and payments and establishing paternity for a child born out of wedlock, except for pregnant women under A.A.C. R9-22-1421, unless the person establishes good cause under 42 CFR 433.147 for not cooperating; and~~
 - b. ~~Identifying and providing information to assist the Administration in pursuing first- and third-parties who may be liable to pay for care and services unless the person establishes good cause for not cooperating;~~
 - 9.8. A person shall take all necessary steps to obtain annuity, pension, retirement, and disability benefits for which a person may be entitled ~~unless the person establishes good cause for not doing so;~~
 - 10.9. State residency under ~~R9-22-305~~ R9-28-403;
 - 11.10. Medical eligibility as specified in ~~Chapter 28, Article 3 of this Chapter~~; and
 - 12.11. Providing information and verification as specified ~~in subsection (D)~~ under Chapter 22, Article 3.
- C. Persons eligible for Title IV-E or Title XVI ~~are only required to meet the conditions under subsection (B)(6), (B)(10), (B)(11) and with respect to trusts, A.R.S. § 36-2934.01. To be determined eligible for ALTCS, a person eligible for benefits under Title IV-E or Title XVI of the Social Security Act shall provide information to allow the Administration to determine:~~
 1. ~~Medical eligibility as specified in Article 3 of this Chapter;~~
 2. ~~Post-eligibility treatment of income as specified in R9-28-408;~~
 3. ~~The existence of trusts in accordance with federal and state law, and~~
 4. ~~Transfer of property as specified in R9-28-409.~~
- D. Verification. If requested by the Administration, a person shall provide information and documentation to verify the following criteria or shall authorize the Administration to verify the following criteria:
 1. ~~Conditions of eligibility as specified in subsection (B); and~~
 2. ~~Other individual circumstances necessary to determine a person's eligibility and post-eligibility treatment of income (share of cost).~~
- E. Documentation of the eligibility decision. The ALTCS eligibility interviewer shall include facts in a person's case record to support the decision on the person's application.
- F. Eligibility effective date. Eligibility is effective the first day of the month that all eligibility requirements are met but no earlier than the month of application.
- D. Eligibility effective date.
 1. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period

Notices of Final Rulemaking

described under R9-22-303.

2. The effective date of eligibility for an applicant who moves into Arizona is no sooner than the date Arizona residency is established.
3. The effective date of eligibility for an inmate applying for medical coverage is the date the applicant no longer meets the definition of an inmate of a public institution.

~~G.E.~~ Notice. The Administration shall send a person a ~~written~~ notice of the decision regarding the person's application. The notice shall include a statement of the action and an explanation of the person's hearing rights as specified in 9 A.A.C. 34 and:

1. ~~If the applicant's eligibility is approved, the notice shall contain:~~
 - a. ~~The effective date of eligibility; and~~
 - b. ~~Post-eligibility treatment of income (share-of-cost) information, which is the amount the person shall pay toward the cost of care.~~
2. ~~If the applicant's eligibility is denied, the notice shall contain:~~
 - a. ~~The effective date of the denial;~~
 - b. ~~A statement detailing the reason for the person's denial, including specific financial calculations and the financial eligibility standard if applicable; and~~
 - e. ~~The legal authority supporting the decision.~~
1. Approval. If the applicant meets all the eligibility requirements and conditions of eligibility of this Article, the Administration or its designee shall approve the application and provide the applicant with an approval notice. The approval notice shall contain:
 - a. The name of each approved applicant.
 - b. The effective date of eligibility for each approved applicant.
 - c. The amount of share of cost, and
 - d. The applicant's right to appeal the decision.
2. Denial. If an applicant fails to meet the eligibility requirements or conditions of eligibility of this Article, the Administration or its designee shall deny the application and provide the applicant with a denial notice. The denial notice shall contain:
 - a. The name of each ineligible applicant.
 - b. The specific reason why the applicant is ineligible.
 - c. The income and resource calculations for the applicant compared to the income or resource standards for eligibility when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard.
 - d. The legal citations supporting the reason for the ineligibility.
 - e. The location where the applicant can review the legal citations, and
 - f. The applicant's right to appeal the decision and request a hearing.

~~H.F.~~ Confidentiality. The Administration shall maintain the confidentiality of a person's record ~~and shall not disclose information regarding the person's financial, medical, or other privacy interests except under A.A.C. R9-22-512.~~

R9-28-402. Categorical Requirements and Coverage Groups Repeal

~~A.~~ Categorical requirements. As a condition of ALTCS eligibility, a person shall meet one of the following categorical requirements in this Section under 42 CFR 435, Subpart F:

1. ~~Aged:~~
 - a. ~~"Aged" means a person who is 65 years of age or older.~~
 - b. ~~A person is considered to be age 65 on the day before the anniversary of birth.~~
 - e. ~~Age shall be verified under 20 CFR 404.715 and 20 CFR 404.716.~~
2. ~~Blind. Blindness shall be determined by the DES Disability Determination Services Administration, under 42 U.S.C. 1382e(a)(2).~~
3. ~~Disabled. A person is considered to be disabled for ALTCS if the person is determined medically eligible under Article 3.~~
4. ~~Child. A child is a person defined in A.A.C. R9-22-1420.~~
5. ~~Pregnant:~~
 - a. ~~Pregnancy shall be medically verified by one of the following licensed health care professionals:~~
 - i. ~~Licensed physician;~~
 - ii. ~~Certified physician's assistant;~~
 - iii. ~~Certified nurse practitioner;~~
 - iv. ~~Licensed midwife; or~~
 - v. ~~Licensed registered nurse, under the direction of a licensed physician.~~
 - b. ~~Written verification of pregnancy shall include the expected date of delivery.~~
6. ~~A specified relative who is the caretaker relative of a deprived child under Section 2 of the AFDC State Plan as it existed on July 16, 1996, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.~~

Notices of Final Rulemaking

B. ~~ALTCS coverage groups. In addition to other requirements in this Article, a person shall meet ALTCS eligibility criteria in one of the following coverage groups:~~

- ~~1. A coverage group under A.R.S. §§ 36-2901(6)(a)(i) or 36-2901(6)(a)(ii);~~
- ~~2. The 210 coverage group specified in 42 CFR 435.210. A person in the 210 coverage group is medically eligible as specified in Article 3 and would be eligible for SSI cash assistance or meets the criteria for AFDC under Section 2 of the AFDC State Plan as it existed on July 16, 1996.~~
- ~~3. The 236 coverage group under 42 CFR 435.236. A person in the 236 coverage group is medically eligible as specified in Article 3 and the person resides in a medical institution.~~
- ~~4. The 217 coverage group under 42 CFR 435.217. A person in the 217 coverage group is medically eligible as specified in Article 3 and the person resides in a home and community-based setting described in R9-28-406(A)(2).~~

R9-28-403. State Residency Repeal

As a condition of eligibility, a person shall be a resident of Arizona as specified in 42 CFR 435.403, December 21, 1990, incorporated by reference and on file with the Administration and Secretary of State. This incorporation contains no future editions or amendments.

R9-28-404. Citizenship and Qualified Alien Status Repeal

As a condition of eligibility, a person shall be:

- ~~1. A citizen of the United States;~~
- ~~2. A qualified alien specified in 8 U.S.C. 1641 and A.R.S. § 36-2903.03, to the extent consistent with federal law; or~~
- ~~3. A nonqualified alien who received ALTCS services on or before August 21, 1996, as specified in Laws 1997, Ch. 300, § 70.~~

R9-28-405. Social Security Enumeration Repeal

As a condition of eligibility, a person shall furnish an SSN, as specified in 42 CFR 435.910 and 435.920.

R9-28-406. ALTCS Living Arrangements

A. Long-term care living arrangements. A person may be eligible for ALTCS services, under Article 2, while living in one of the following settings:

1. Institutional settings:
 - a. ~~A NF Nursing Facility (NF)~~ defined in 42 U.S.C. 1396r(a),
 - b. ~~An IMD Institution for Mental Diseases (IMD)~~ for a person who is either under age 21 or age 65 or older ~~or a person aged 21 through 64 for up to 30 days per admission and no more than 60 days per contract year under the Administration's Section 1115 Waiver with CMS,~~
 - c. An ICF-MR Intermediate Care Facility for the Mentally Retarded (ICF-MR) for a person with developmental disabilities,
 - d. A hospice (free-standing, hospital, or nursing facility subcontracted beds) defined in A.R.S. § 36-401; or
2. Home and community-based services (HCBS) settings:
 - a. A person's home defined in R9-28-101(B), or
 - b. Alternative HCBS settings defined in R9-28-101(B).

B. ~~ALTCS acute care living arrangements. A person applying for or receiving ALTCS coverage shall be eligible for only ALTCS acute care coverage in the following living arrangements, settings, or locations:~~

- ~~1. The gross income limit is 300 percent of the FBR for a person meeting the requirements of the 236 coverage group under R9-28-402(B) and who resides in one of the following settings:~~
 - ~~a. A noncertified medical facility, or~~
 - ~~b. A medical facility that is registered with AHCCCS but does not have a contract with an ALTCS program contractor, or~~
 - ~~c. A location outside of Arizona if the person is temporarily absent from Arizona.~~
- ~~2. The net income limit is 100 percent of the FBR for a person who does not meet the requirements of the 217 or 236 coverage groups specified in R9-28-402(B) and who resides in one of the following settings:~~
 - ~~a. At home or in an alternative HCBS setting if a person refuses HCBS service; or~~
 - ~~b. A room in an assisted living center, or a licensed assisted living home or center which is not registered with AHCCCS.~~

B. ALTCS acute care living arrangements.

1. A person applying for and otherwise entitled to receive ALTCS coverage shall receive only ALTCS acute care coverage if residing in one of the following living arrangements, settings, or locations:
 - a. A noncertified medical facility, or
 - b. A medical facility that is registered with AHCCCS but does not have a contract with an ALTCS program contractor, or
 - c. At home or in an alternative HCBS setting when the person refuses HCBS services, or
 - d. A licensed or certified HCBS facility that is not registered with AHCCCS.

Notices of Final Rulemaking

2. Eligibility income limits.

- a. For a person residing in a setting described in subsection (1)(a) or (1)(b), the gross income limit is 300 percent of the Federal Benefit Rate (FBR).
- b. For a person residing in a setting described in subsection (1)(c) or (1)(d), the net income limit is 100 percent of the FBR.

C. Inmate of a public institution. An inmate of a public institution is not eligible for the ALTCS program if federal financial participation (FFP) is not available as described under R9-22-310.

R9-28-407. Resource Criteria for Eligibility

A. The following Medicaid-eligible persons shall be deemed to meet the resource requirements for ALTCS eligibility unless ineligible due to federal and state laws regarding trusts.

1. A person receiving Supplemental Security Income (SSI);
2. A person receiving Title IV-E Foster Care Maintenance payment; or
3. A person receiving a Title IV-E Adoption Assistance.

B. Except as provided in subsection (C), if a person's ALTCS eligibility is most closely related to SSI and is not included in subsection (A), the Administration shall determine eligibility using resource criteria in 42 U.S.C. 1382(a)(3)(1)(B), 42 U.S.C. 1382b, and 20 CFR 416 Subpart L. The resource limit for an individual is \$2,000 or \$3,000 for a couple under 20 CFR 416.1205.

C. The Administration permits the following exceptions to the resource criteria for a person identified in subsection (B):

1. Resources of the spouse or parent of a minor child are disregarded beginning the first day in the month the person is institutionalized.
2. The value of household goods and personal effects is excluded.
3. The value of oil, timber, and mineral rights is excluded.
4. The value of all of the following shall be disregarded:
 - a. Term insurance;
 - b. Burial insurance;
 - c. Assets that a person has irrevocably assigned to fund the expense of a burial;
 - d. The cash value of all life insurance if the face value does not exceed \$1,500 total per insured person and the policy has not been assigned to fund a pre-need burial plan or has a legally binding designation as a burial fund;
 - e. The value of any burial space held for the purpose of providing a place for the burial of the person, a spouse, or any other member of the immediate family;
 - f. \$1,500 of the equity value of an asset that has a legally binding designation as a burial fund or a revocable burial arrangement if there is no irrevocable burial arrangement;
 - g. During the time a person remains continuously eligible, all appreciation in the value of the assets in subsection (C)(4)(f) will be disregarded; and
 - h. The amount of a payment refunded by a nursing facility after ALTCS approval is only excluded for six months beginning with the month the refund was received. The Administration shall evaluate the refund in accordance with R9-28-409 if transferred without receiving something of equal value.

D. For an institutionalized spouse, a resource disregard is allowed under 42 U.S.C. 1396r-5(c).

E. Trusts are evaluated in accordance with federal and state laws to determine eligibility.

~~F. A person is not eligible for long-term care services if countable resources exceed the following limits:~~

- ~~1. For a SSI-related person identified in subsection (B), the limit is \$2,000 or \$3,000 per couple under 20 CFR 416.1205.~~
- ~~2. For a person eligible under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII), there is no resource limit.~~

~~G.E.~~A person shall provide information and verification necessary to determine the countable value of resources.

R9-28-408. Income Criteria for Eligibility

A. The following Medicaid-eligible persons shall be deemed to meet the ~~resource~~ income requirements for ALTCS eligibility unless ineligible due to federal and state laws regarding trusts.

1. A person receiving Supplemental Security Income (SSI);
2. A person receiving Title IV-E Foster Care Maintenance Payments; or
3. A person receiving Title IV-E Adoption Assistance.

B. ~~If a person's ALTCS eligibility is most closely related to SSI and~~ the person is not included in subsection (A), the Administration shall count the income described in 42 U.S.C. 1382a and 20 CFR 416 Subpart K to determine eligibility with the following exceptions:

1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are also excluded in determining gross income to determine eligibility;
2. Income of the parent or spouse of a minor child is counted as part of income under 42 CFR 435.602, except that the income of the parent or spouse is disregarded for the month beginning when the person is institutionalized;

Notices of Final Rulemaking

3. In-kind support and maintenance, under 42 U.S.C. 1382a(a)(2)(A), are excluded for both net and gross income tests;
 4. The income exceptions under A.A.C. R9-22-1503(B) apply to the net income test; and
 5. Income described in subsection ~~(D)~~ (C) is excluded.
- C.** For a person whose eligibility is determined under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), or 42 U.S.C. 1396a(a)(10)(A)(i)(VII), the methodology in A.A.C. R9-22-1420 through R9-22-1426 is used to determine eligibility in accordance with 42 CFR 435.602. Income standards are then applied as described in A.A.C. R9-22-1428.
- D-C.** The following are income exceptions:
1. Disbursements from a trust are considered in accordance with federal and state law; and
 2. For an institutionalized spouse, a person defined in 42 U.S.C. 1396r-5(h)(1), income is calculated in accordance with 42 U.S.C. 1396r-5(b).
- E.** As a condition of eligibility for ALTCS, countable income shall be less than or equal to the following limits:
1. For a person in either the 217 or 236 coverage group specified in R9-28-402(B), 300 percent of the FBR;
 2. For a person or a couple in the SSI-related 210 coverage group specified in R9-28-402(B), 100 percent of the FBR;
 3. For a person who is under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII) and is:
 - a. A child who is at least age six but less than age 19; 100 percent of the FPL, adjusted by household size;
 - b. A child age one through five; 133 percent of the FPL, adjusted by household size;
 - c. A child less than age one; 140 percent of the FPL, adjusted by household size; or
 - d. A pregnant woman; 150 percent of the FPL, adjusted by household size.
- D.** Income eligibility. Except as provided in R9-28-406(B)(2)(b), countable income shall not exceed 300 percent of the FBR.
- E-E.** The ~~Director~~ Administration shall determine the amount a person shall pay for the cost of ALTCS services and the post-eligibility treatment of income (share-of-cost) under A.R.S. § 36-2932(L) and 42 CFR 435.725 or 42 CFR 435.726. The ~~Director~~ Administration shall consider the following in determining the share-of-cost:
1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are excluded in determining share-of-cost.
 2. SSI benefits paid under 42 U.S.C. 1382(e)(1)(E) and (G) to a person who receives care in a hospital or nursing facility are not included in calculating the share-of-cost.
 3. The share-of-cost of a person with a spouse is calculated as follows:
 - a. If an institutionalized person has a community spouse under 42 U.S.C. 1396r-5(h), share-of-cost is calculated under R9-28-410 and 42 U.S.C. 1396r-5(b) and (d); and
 - b. If an institutionalized person does not have a community spouse, share of cost is calculated solely on the income of the institutionalized person.
 4. Income assigned to a trust is considered in accordance with federal and state law.
 5. The following expenses are deducted from the share-of-cost of an eligible person to calculate the person's share-of-cost:
 - a. A personal-needs allowance equal to 15 percent of the FBR for a person residing in a medical institution for a full calendar month. A personal-needs allowance equal to 300 percent of the FBR for a person who receives or intends to receive HCBS or who resides in a medical institution for less than the full calendar month;
 - b. A spousal allowance, equal to the FBR minus the income of the spouse, if a spouse but no children remain at home;
 - c. A family household allowance equal to the standard specified in Section 2 of the ~~AFDC~~ Aid for Families with Dependent Children (AFDC) State Plan as it existed on July 16, 1996 for the number of family household members minus the income of the family household members if a spouse and children remain at home;
 - d. Expenses for the medical and remedial care services listed in subsection (6) if the expenses have not been paid or are not subject to payment by a third-party, the person still has the obligation to pay the expense, and one of the following conditions is met:
 - i. The expense represents a payment made and reported to the Administration during the application period or a payment reported to the Administration no later than the end of the month following the month in which the payment occurred and the expense has not previously been allowed a share-of-cost deduction; or
 - ii. The expense represents the unpaid balance of an allowed, noncovered medical or remedial expense, and the expense has not been previously a share-of-cost deduction;
 - e. An amount determined by the Director for the maintenance of a single person's home for not longer than six months if a physician certifies that the person is likely to return home within that period; or
 - f. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to third-party reimbursement; and
 6. In the post-eligibility calculation of income; The deductible expense under subsection (5)(b) shall not include any amount for a service covered under the Title XIX State Plan. The deductible expense may include the TPL deductible, co-insurance, and co-payment charges for the following medically necessary services:
 - a. ~~The Administration recognizes that the following medical and remedial care services are not covered under the Title XIX State Plan, nor covered by a program contractor for a person determined to need institutional services~~

Notices of Final Rulemaking

~~under this Article when the medical or remedial care services are medically necessary for the person:~~

- ~~i. a.~~ Nonemergency dental services for a person who is age 21 or older;
- ~~ii. b.~~ Hearing aids and hearing aid batteries for a person who is age 21 or older;
- ~~iii. c.~~ Nonemergency eye care and prescriptive lenses for a person who is age 21 or older;
- ~~iv. d.~~ Chiropractic services, including treatment for subluxation of the spine, demonstrated by x-ray;
- ~~v. e.~~ Orthognathic surgery for a person who is age 21 or older; or
- f. Co-payments for Medicare Part D prescriptions, if not paid by the State.
- ~~b. g.~~ On a case-by-case basis, other noncovered medically necessary services that a person petitions the Administration for and the Director approves.

~~G-E.~~ A person shall provide information and verification of income under A.R.S. § 36-2934(G) and 20 CFR 416.203.

R9-28-409. Transfer of Assets

- A.** The provisions in this Section apply to an institutionalized person who has, or whose spouse has, transferred assets and received less than the fair market value (uncompensated value) as specified in A.R.S. § 36-2934(B) and 42 U.S.C. 1396p(c)(1)(A), August 10, 1993 July 1, 2009, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- B.** A person shall report transfer of assets. The Administration shall evaluate all transfers ~~occurring made~~ during or after the look-back period under 42 U.S.C. 1396p(c)(1)(B), August 10, 1993 July 1, 2009, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments. The person shall provide verification of any transfer.
- C.** Certain transfers are permitted under 42 U.S.C. 1396p(c)(2), August 10, 1993 July 1, 2009, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- D.** If the Administration determines a disqualification period applies due to a transfer, and the person is otherwise eligible, the person may remain eligible for ALTCS acute care services but shall be disqualified for receiving ALTCS coverage under 42 U.S.C. 1396p(c)(1)(~~C~~)(E), August 10, 1993 July 1, 2009, which is incorporated by reference and on file with the Administration and the Secretary of State. This incorporation contains no future editions or amendments, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- ~~E.~~** ~~The period of disqualification for transfers shall be computed by dividing the cumulative uncompensated value of the transferred assets by the average cost for a private pay patient for nursing care services at the time of application:~~
 - ~~1. For single or multiple transfers occurring in the same calendar month, the sum of all uncompensated value shall be divided by the monthly private pay rate. Disregarding fractions, the result of this calculation equals the number of months of ineligibility.~~
 - ~~2. For multiple transfers occurring in different calendar months, the total uncompensated value for each transfer of assets shall be determined under subsection (E)(1) but, if the periods of ineligibility overlap, the period of ineligibility shall run consecutively. Fractions are disregarded at the end of the entire period.~~
 - ~~3. For multiple transfers occurring in different months, the total uncompensated value for each transfer shall be determined under subsection (E)(1), but if the periods of ineligibility do not overlap, each period of ineligibility shall be treated under subsection (E)(1).~~
- E.** Period of disqualification for transfers.
 - 1. Calculating a period of disqualification at application. The uncompensated value of all transfers shall be divided by the monthly private pay rate. The result of this calculation equals the number of months of ineligibility.
 - 2. Calculating a period of disqualification after approval:
 - a. For one or more transfers occurring in one calendar month or in consecutive months, the period of disqualification is determined under subsection (E)(1). The period of disqualification begins with the month that the first transfer was made.
 - b. For transfers occurring in nonconsecutive calendar months, the period of disqualification for each transfer of assets shall be determined separately under subsection (E)(1) to determine if the periods of disqualification overlap.
 - i. Periods of disqualification that overlap shall be added together and shall run consecutively, beginning with the month the first transfer was made.

Notices of Final Rulemaking

- ii. Periods of disqualification that do not overlap are each applied separately beginning the month that the transfer was made.
- F. Transfers of assets for less than fair market value are presumed to have been made to establish eligibility for ALTCS services.
- G. Rebuttal of disqualification.
 - 1. A person found ineligible for ALTCS services by reason of a transfer of assets for uncompensated value shall have the right to rebut the disqualification for reasons stated under 42 U.S.C. 1396p(c)(2)(C), August 10, 1993 July 1, 2009, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 - 2. The person shall have the burden of rebutting the presumption.
 - 3. If a person rebuts a transfer on the basis of debt repayment, the Administration shall determine the validity of the debt and payment amount under A.R.S. § 44-101.
- H. Undue hardship. ~~A period of disqualification for ALTCS services due to a transfer may be waived by the Director if the person is otherwise eligible and a substantial showing is made by clear and convincing evidence that:~~
 - ~~1. The person is unable to obtain necessary medical care without ALTCS eligibility, and~~
 - ~~2. Is in imminent danger of death.~~

The transfer penalty period may be waived if denial of eligibility for long term care services creates an undue hardship.

 - 1. The Administration shall consider whether the transfer penalty period can be waived when:
 - a. The individual is otherwise eligible for ALTCS benefits and application of the transfer of assets provision would deprive the individual of medical care such that the individual's life or health would be in endangered, or
 - b. The individual is otherwise eligible for ALTCS benefits and is deprived of food, clothing, shelter or other necessities of life as evidenced by the fact that the individual's income is less than or equal to the Federal Poverty Level (FPL);
 - 2. The transfer penalty period shall be waived when:
 - a. The individual is incapacitated as established by the Court or by a physician; and
 - b. The individual who had the legal authority to handle the applicant's finances has violated the terms of that legal authority; and
 - c. An individual acting on the applicant's behalf has exhausted all legal remedies to regain the asset, such as but not limited to, filing a police report and seeking recovery through civil court.
 - 3. The transfer penalty period shall not be waived when:
 - a. The applicant was mentally competent and would have been aware of the consequences of the transfers at the time the transfers occurred; or
 - b. The applicant gave another person specific legal authority to make the transfers, such as a conservator, or a person granted the applicant's financial power of attorney when the applicant was competent to do so, and the person did not violate the limits of that authority in making the transfers.

R9-28-410. Community Spouse

- A. The methodology in this Section applies to an institutionalized person who has a community spouse.
- B. If the institutionalized person's most current period of continuous institutionalization began on or after September 30, 1989, the Administration shall use the methodology for the treatment of resources under 42 U.S.C. 1396r-5(c).
 - 1. The following resource criteria shall be used in addition to the criteria specified in R9-28-407 to be eligible:
 - a. Resources owned by a couple at the beginning of the first continuous period of institutionalization from and after September 30, 1989, shall be computed from the first day of institutionalization. The total value of resources owned by the institutionalized spouse and the community spouse, and a spousal share equal to one-half of the total value, are computed under 42 U.S.C. 1396r-5(c)(1).
 - b. The Community Spouse Resource ~~Reduction~~ Deduction (CSR~~D~~D) is calculated under 42 U.S.C. 1396r-5(f)(2).
 - c. The CSR~~D~~D is subtracted from the total resources of the couple to determine the amount of the couple's resources considered available to the institutionalized spouse at the time of application under 42 U.S.C. 1396r-5(c)(2).
 - i. Resources in excess of the CSR~~D~~D must be equal to or less than the standard for a person specified in R9-28-407.
 - ii. The CSR~~D~~D is allowed as a deduction for 12 consecutive months beginning with the first month in which the institutionalized spouse is eligible for ALTCS benefits. Beginning with the 13th month, the separate property of the institutionalized spouse must be within the resource standard for a person specified in R9-28-407.
 - iii. If a person who was previously eligible for ALTCS as an institutionalized person with a community spouse reapplies for ALTCS after a break in institutionalization of more than 30 days, the CSR~~D~~D will be allowed as a deduction from resources for a 12-month period in addition to the period in subsection (c)(ii).
 - 2. Resources are excluded as specified in R9-28-407, except that one vehicle is totally excluded regardless of its value, and any additional vehicles are included using equity value.

Notices of Final Rulemaking

3. The Director may grant eligibility if the Administration determines that a denial of eligibility would create an undue hardship for the institutionalized spouse.
- C. This Section applies to the income eligibility and post-eligibility treatment of income beginning September 30, 1989, regardless of when the first period of institutionalization began.
 1. Income payments are attributed to the institutionalized person and the community spouse under 42 U.S.C. 1396r-5(b)(2).
 2. Income is excluded as specified in R9-28-408.
 3. The institutionalized spouse's income eligibility is determined by combining the income of the institutionalized person and the community spouse and dividing by two. If the institutionalized person is not eligible using this method, the income eligibility shall be based on the income received in the person's name.
 4. The following allowances described in 42 U.S.C. 1396r-5(d)(1) and (2) are allowed as deductions from the institutionalized spouse's income in determining share-of-cost:
 - a. A personal-needs allowance specified in R9-28-408~~(f)(5)(a)(E)(5)~~;
 - b. A community spouse monthly income allowance, but only to the extent that the institutionalized spouse's income is made available to or for the benefit of the community spouse;
 - c. A family allowance for each family member equal to one-third of the amount remaining after deducting the countable income of the ~~family~~ household member from a ~~minimum monthly needs allowance~~ Minimum Monthly Maintenance Needs Allowance (MMMNA);
 - d. An amount for medical or remedial services as specified in R9-28-408; and
 - e. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to third-party reimbursement.
- D. Transfers.
 1. The institutionalized spouse may transfer to any of the following an amount of resources equal to the CSRD without affecting eligibility under 42 U.S.C. 1396r-5(f). The institutionalized spouse may transfer resources to:
 - a. The community spouse; or
 - b. Someone other than the community spouse if the resources are for the sole benefit of the community spouse.
 2. The institutionalized spouse is allowed a period of 12 consecutive months, beginning with the first month of eligibility, to transfer resources in excess of the resource standard in R9-28-407~~(E)(2)~~ to the persons listed in subsection (D)(1).
 3. All other transfers by the institutionalized person or transfers by the community spouse are treated under the provisions in R9-28-409.
- E. Specific hearing rights as described under 9 A.A.C. 34 apply to a person whose eligibility is determined under this Section.
 1. The institutionalized spouse or the community spouse is entitled to a fair hearing if dissatisfied with the determination of any of the following:
 - a. The community spouse monthly income allowance,
 - b. The amount of monthly income allocated to the community spouse,
 - c. The computation of the spousal share of resources,
 - d. The attribution of resources, or
 - e. The CSRD.
 2. The hearing officer may increase the amount of the MMMNA if either the community spouse or institutionalized spouse establishes that the community spouse needs income above the established MMMNA due to exceptional circumstances.
 3. The hearing officer may increase the amount of the CSRD to allow the community spouse to retain enough resources to generate income to meet the MMMNA. The hearing officer may allow the community spouse to retain an amount of resources necessary to purchase a single premium life annuity that would furnish monthly income sufficient to bring the community spouse's total monthly income up to the MMMNA.

R9-28-411. Changes, Redeterminations, and Notices

A. Reporting and verifying changes.

1. A person shall report to the ALTCS eligibility office the following changes for a person, a person's spouse, or a person's dependent children under 42 CFR 435.916:
 - a. A change of address;
 - b. An admission to or discharge from a medical facility, public institution, or private institution;
 - c. A change in the household's composition;
 - d. A change in income;
 - e. A change in resources;
 - f. A determination of eligibility for other benefits;
 - g. A death;
 - h. A change in marital status;

Notices of Final Rulemaking

- i. An improvement in the person's medical condition;
 - j. A change in school attendance;
 - k. A change in Arizona state residency;
 - l. A change in citizenship or alien status;
 - m. Receipt of an SSN under ~~R9-28-405~~ R9-22-305;
 - n. A transfer of assets under R9-28-409;
 - o. A change in trust income and disbursements in accordance with state and federal law;
 - p. A change in first- or third-party liability that may be responsible for payment of all or a portion of the person's medical costs;
 - q. A change in first-party medical insurance premiums;
 - r. A change in the household expenses used to calculate the community spouse monthly income allowance described in R9-28-410;
 - s. A change in the amount of the community spouse monthly income allowance that is provided to the community spouse by the institutionalized spouse under R9-28-410; and
 - t. Any other change that may affect the person's eligibility or share-of-cost.
2. A change shall be reported either orally or in writing ~~and shall include as described under R9-22-306:~~
 - a. ~~The name of the affected person;~~
 - b. ~~The change;~~
 - c. ~~The date the change happened;~~
 - d. ~~The name of the person reporting the change; and~~
 - e. ~~The person's Social Security or case number, if known, under A.R.S. § 36-2934.~~
 3. ~~A person shall provide verification of changes upon request, under A.R.S. § 36-2934, if needed to redetermine eligibility or to re-calculate post-eligibility computation of income.~~
 4. ~~A person shall report anticipated changes in advance, as soon as the future event becomes known.~~
 5. ~~A person shall report other changes events within 10 days of the date the change occurred.~~
- B.** Processing of changes and redeterminations. A person's eligibility shall be redetermined at least one time every 12 months and when changes occur, under 42 CFR 435.916. A person's share-of-cost, specified in R9-28-408, shall be redetermined whenever a change occurs that may affect the post-eligibility computation of income.
- C.** Actions that may result from a redetermination or change. Processing a redetermination or change shall result in one of the following findings:
1. No change in eligibility or the post-eligibility computation of income;
 2. Discontinuance of eligibility if a condition of eligibility is no longer met;
 3. Suspension of eligibility if a condition of eligibility is temporarily not met;
 4. A change in the post-eligibility computation of income and the person's share-of-cost; or
 5. A change in service from ALTCS to ALTCS acute care services, or from ALTCS acute care services to ALTCS, caused by changes in a person's living arrangement, specified in R9-28-406, or a transfer of assets specified in R9-28-409.
- D.** Notices.
1. Contents of notice. The Administration shall issue a notice when an action is taken regarding a person's eligibility or computation of share-of-cost. The notice shall contain the following information:
 - a. A statement of the action being taken;
 - b. The effective date of the action;
 - c. The specific reason for the intended action;
 - d. The actual figures used in the eligibility determination and specify the amount by which the person exceeds income standards if eligibility is being discontinued because either a person's resources exceed the resource limit ~~specified in R9-28-407(E)~~, or a person's income exceeds the income limit ~~specified in R9-28-408(E)~~;
 - e. The specific law or regulation that supports the action, or a change in federal or state law that requires an action;
 - f. An explanation of a person's right to request an evidentiary hearing as described under 9 A.A.C. 34; and
 - g. An explanation of the date by which a request for hearing must be received so that eligibility or the current share-of-cost may be continued.
 2. Advance notice of changes in eligibility or share-of-cost. "Advance notice" means a notice that is issued to a person at least 10 days before the effective date of change, ~~under 42 CFR 435.919~~. Except as specified in subsection (D)(3), advance notice shall be issued whenever the following adverse action is taken:
 - a. To discontinue or suspend eligibility if an eligible person no longer meets a condition of eligibility, either ongoing or temporarily;
 - b. To affect post-eligibility computation of income and increase a person's share-of-cost; or
 - c. To reduce benefits from ALTCS to ALTCS acute care services due to a change from a long-term care living arrangement to an acute care living arrangement, specified in R9-28-406(B), or due to a transfer with uncompensated value, specified in R9-28-409.

Notices of Final Rulemaking

3. ~~Under 42 CFR 431.213, notice shall be issued to a person to discontinue eligibility or to increase the share-of-cost, no later than the effective date of action if:~~ Adverse actions. An applicant or member may appeal, as described under 9 A.A.C. 34, by requesting a hearing from the Administration or its designee concerning any of the adverse actions if:
 - a. A person provides a clear, written statement, signed by the person, that a person no longer desires services;
 - b. A person provides information that requires termination of eligibility or an increase in the share-of-cost and the person signs a clear written statement waiving advance notice;
 - c. A person cannot be located and mail sent to that person has been returned as undeliverable;
 - d. A person has been admitted to a public institution where the person is ineligible for ALTCS under R9-28-406; or
 - e. A person has been approved for Medicaid in another state;
 - f. The Administration has information that confirms the death of the person;
 - g. The person's primary care provider has prescribed a change in the level of medical care; or
 - h. The notice involves an adverse determination regarding the PAS, specified in A.R.S. § ~~36-2536~~ 36-2936.
- E. Transitional. HCBS services may be provided to a person who is no longer at risk of institutionalization but who continues to require significant long-term care services under A.R.S. § 36-2936(D).

R9-28-413. Enrollment with an ~~EPD~~ EPD Elderly and Physically Disabled (EPD) Program Contractor

- A. A member's enrollment with ~~one an~~ an EPD program contractor. The Administration shall enroll an ALTCS elderly or physically disabled member with ~~the one an~~ an EPD program contractor assigned to that GSA.
- B. New member makes a choice of an EPD program contractor ~~on or after October 1, 2000~~. The Administration shall provide a new member an opportunity to choose an EPD program contractor, if an ALTCS member is elderly or physically disabled, and lives in a GSA served by more than one EPD program contractor.
- C. New member who makes no choice of an EPD program contractor ~~on or after October 1, 2000~~. The Administration shall enroll an elderly or physically disabled new member that lives in a GSA with more than one EPD program contractor and who makes no choice of an EPD program contractor under the following:
 1. Criteria. The Administration will prioritize enrollment based on continuity of care and enroll a member with an EPD program contractor chosen under the following criteria, including but not limited to:
 - a. A member's living arrangement, and
 - b. A member's primary care practitioner.
 2. Algorithm. The Administration shall enroll a member through an algorithm as specified in contract, when a member has a choice of more than one EPD program contractor and the criteria in subsection (C)(1) does not apply.
- ~~D. A member enrolled with an EPD program contractor prior to October 1, 2000, and is enrolled in the system after October 1, 2000.~~
 - ~~1. Choice. The Administration shall request an existing member residing in a GSA with more than one EPD program contractor to choose an EPD program contractor.~~
 - ~~2. A member makes no choice. If a member makes no choice, the Administration will continue enrollment with a member's existing EPD program contractor. If that existing EPD program contractor is not awarded a bid, the member will be enrolled with an EPD program contractor as specified in Section (C).~~

R9-28-414. Enrollment with the DD Program Contractor

- ~~A.~~ A member's DD program contractor. The Administration shall enroll a member including an American Indian with the DES Division of Developmental Disabilities as specified in A.R.S. § 36-2940, if the ALTCS member is eligible for services for the developmentally disabled ~~services~~.
- ~~B. Indian on and off reservation. The Administration shall enroll an Indian ALTCS member who is developmentally disabled, with the DES Division of Developmental Disabilities. This enrollment shall be made whether the member is considered to be residing on or off reservation.~~

R9-28-415. Enrollment with a Tribal Program Contractor

- A. On-reservation. Notwithstanding R9-28-412, the Administration shall enroll ~~a Native American~~ an American Indian ALTCS member who is elderly or physically disabled with the ALTCS tribal program contractor as specified in A.R.S. § 36-2932 if the person:
 1. Lives on-reservation of a tribe participating as an ALTCS tribal program contractor, or
 2. Lived on-reservation of a tribe participating as an ALTCS tribal program contractor immediately prior to placement in an off-reservation NF or alternative HCBS setting.
- B. Off-reservation. The Administration shall enroll ~~a Native American~~ an American Indian ALTCS member who is elderly or physically disabled with an EPD program contractor under R9-28-413, if the member lives off-reservation, and does not have on-reservation status as specified in subsection (A)(2).

R9-28-416. Enrollment with the ~~FFS~~ FFS Fee-for-Service (FFS) Program

- A. No tribal or EPD program contractor in GSA. The Administration shall enroll an ALTCS elderly or physically disabled member who resides in an area with no ALTCS tribal program contractor or EPD program contractor in the AHCCCS FFS program under A.R.S. § 36-2945.

Notices of Final Rulemaking

- B.** Prior period coverage. The Administration shall enroll a member in AHCCCS fee-for-service program if a member is eligible for ALTCS services only during prior period coverage.
- C.** The Administration shall enroll a member in AHCCCS fee-for-service program if the member is eligible for ALTCS services during the prior quarter period.

R9-28 418. Disenrollment

The Administration shall disenroll an ALTCS member on the last day of the month following receipt of appropriate notification under R9-28-411 except:

1. The Administration shall disenroll an ALTCS member who dies. A member's last day of enrollment shall be the date of death.
2. The Administration ~~may~~ shall disenroll a member immediately ~~if requested~~ when the member voluntarily withdraws from the ALTCS program.
3. If ALTCS benefits have been continued pending an eligibility appeal decision and the discontinuance is upheld as specified in 9 A.A.C. 34, the Administration shall disenroll a member effective on the date of the hearing decision.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

**CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
CHILDREN'S HEALTH INSURANCE PROGRAM**

[R14-04]

PREAMBLE

<u>1. Article, Part, or Section Affected (as applicable)</u>	<u>Rulemaking Action:</u>
R9-31-301	Amend
R9-31-302	Amend
R9-31-303	Amend
R9-31-304	Amend
R9-31-305	Amend
R9-31-306	Amend
R9-31-308	Amend
R9-31-309	Amend
R9-31-310	Amend
R9-31-1402	Amend
R9-31-1416	Amend
R9-31-1420	Amend
Article 17	Repeal
R9-31-1701	Repeal
R9-31-1702	Repeal
R9-31-1703	Repeal
R9-31-1704	Repeal
R9-31-1705	Repeal
R9-31-1706	Repeal
R9-31-1707	Repeal
R9-31-1708	Repeal
R9-31-1709	Repeal
R9-31-1710	Repeal
R9-31-1711	Repeal
R9-31-1712	Repeal
R9-31-1713	Repeal
R9-31-1716	Repeal
R9-31-1717	Repeal
R9-31-1718	Repeal
R9-31-1719	Repeal
R9-31-1720	Repeal
R9-31-1721	Repeal
R9-31-1722	Repeal
R9-31-1723	Repeal
R9-31-1724	Repeal
R9-31-1725	Repeal

Notices of Final Rulemaking

R9-31-1726	Repeal
R9-31-1727	Repeal
R9-31-1728	Repeal
R9-31-1729	Repeal
R9-31-1730	Repeal
R9-31-1731	Repeal
R9-31-1732	Repeal
R9-31-1733	Repeal
R9-31-1734	Repeal
R9-31-1735	Repeal

2. Citations to the agency's statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. § 36-2986

Implementing statute: A.R.S. § 36-2983

Federal statute: 42 CFR Parts 431, 435, and 457

17144 Federal Register / Vol. 77, No. 57 / Friday, March 23, 2012 / Rules and Regulations

Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted on March 30, 2010), and together referred to as the Affordable Care Act of 2010 (Affordable Care Act)

3. The effective date of the rule:

January 7, 2014. The agency requested an immediate effective date (upon filing with the Secretary of State) as specified in A.R.S. § 41-1032(A). The agency believes this rulemaking meets the immediate effective date requirements based on the following:

2. To avoid a violation of federal law or regulation or state law, if the need for an immediate effective date is not created due to the agency's delay or inaction.

3. To comply with deadlines in amendments to an agency's governing statute or federal programs, if the need for an immediate effective date is not created due to the agency's delay or inaction.

4. To provide a benefit to the public and a penalty is not associated with a violation of the rule.

These exceptions apply to this rulemaking since the Affordable Care Act and ARS 36-2901.07 require the Administration to implement the higher federal poverty limit percentages and increase to the age limit for children in the foster care system. Therefore benefiting the public by providing coverage to more uninsured Arizona residents, The ACA requires this change to be effective January 1, 2014. Neither the ACA, the state statutes, nor the proposed rules impose any penalty for a violation of the rules. The Administration will rely on federal law for the first seven days of January until the rule is effective, no penalties or effects are associated with the different effective date. The Administration had to wait for CMS to approve the eligibility FPL requirements which caused a delay in filing.

4. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 19 A.A.R. 3156, October 11, 2013

Notice of Proposed Rulemaking: 19 A.A.R. 3113, October 11, 2013

5. The agency's contact person who can answer questions about the rulemaking:

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson St.
Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSrules@azahcccs.gov

Web site: www.azahcccs.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Administration is promulgating rule amendments as result of the Affordable Care Act of 2010 and Arizona Laws 2013, First Special Session, Chapter 10 (House Bill 2010). The majority of the significant amendments exist within Chapter 22, acute care eligibility, but as a result of this review the Administration has reviewed the eligibility require-

Notices of Final Rulemaking

ments existing within Chapter 31, KidsCare eligibility. The proposed changes are to ensure clarity, conciseness and the accuracy of the parallel eligibility requirements for the KidsCare program, such as, changes to processes for determining and redetermining eligibility including changes to accommodate on line applications and internet-based verification of income, citizenship and alien status, state residence, and other eligibility factors; and miscellaneous changes to clarify and conform to federal requirements. These proposed rules are to be effective January 1, 2014.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

A study was not referenced or relied upon for the making of these rules.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable.

9. A summary of the economic, small business, and consumer impact:

The proposed rule changes will not have a significant impact on funds used for the coverage of KidsCare Medicaid applicants the substance of the impact is mainly on the acute population as described below:

The proposed rule changes will have a high impact on funds used for the coverage of Arizona Medicaid applicants. The Administration anticipates that for the first nine months of implementation for federal fiscal year (January 2014 through September 30, 2014) there will be a total fund expenditure of \$1,583,076,500 of both federal and state funds and for federal fiscal year (October 1, 2014 through September 30, 2015) there will be a total fund expenditure of \$2,768,972,900 of both federal and state funds.

	FFY 2014	FFY 2015
Eligible Adults with 100-133% FPL (aka Adult Expansion)	169,631,800	399,977,600
Childless Adults with 0-100% FPL	1,097,117,200	1,769,009,600
Newly Eligible children ages 6-18 with 100-133% FPL	68,636,700	127,443,400
Currently Eligible but not enrolled	247,396,400	471,762,200
Former Foster Children between ages 21-26	294,400	780,100
<u>GRAND TOTAL</u>	<u>1,583,076,500</u>	<u>2,768,972,900</u>

It is estimated that the cost and benefit of the increased coverage of individuals within certain federal poverty levels as directed by the Affordable Care Act will have an impact on the implementing agencies, contractors, providers, small businesses and consumers.

Minimal impact = up to \$1M

Moderate impact = \$1M to \$10M

High impact = \$10M on up

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

No significant changes were made between the proposed rulemaking and the final rulemaking. Changes were made between the proposed rulemaking and the final rulemaking as a result of the public comments submitted, see item 11, and rewritten items for clarity, such as R9-31-1402 was updated to cross-reference the FPL % changes as described under chapter 22 since the FPL% was changed as directed by the Affordable Care Act. In addition, technical and grammatical changes have been made as a result of review from the Governor's Regulatory Review Council.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

One comment was received as of the close of the comment period of November 12, 2013 for Chapter 31.

Notices of Final Rulemaking

<u>Numb:</u>	<u>Date/Commenter:</u>	<u>Comment:</u>	<u>Response:</u>
1	11/12/13 Ellen Katz William Morris Institute for Justice	<p>R9-31-1402</p> <p>Section B. The rule provides that a premium is imposed if the household income is greater than 100% of the federal poverty level. A household with MAGI up to 133% (138% with the 5% income disregarded) is eligible for Medicaid and no premiums are allowed for these persons. In addition, a younger child is eligible for AHCCCS when the household income exceeds 138%. <i>See</i> R9-22-1427C. Effective January 1, 2014, 42 C.F.R. § 447.55 sets forth the premiums that are allowed for different categories of eligible persons whose incomes exceed 150%. In addition, 42 C.F.R. § 447.56 sets forth the limitations on premiums and cost sharing. All the income and premium amounts need to be revised to reflect the increased Medicaid eligibility and the ACA regulations on cost-sharing cited above. Finally, state law only allows for premiums for children whose household income exceeds 150%, A.R.S. 36-2982(E), but even that law appears to conflict with the heightened income eligibility for Medicaid children as noted above</p> <p>In several sections, the proposed rule refers to Article 9, Chapter 22 and our comments above apply here as well.</p> <p>Finally, the federal Children's Health Insurance Program Reauthorization Act, 42 U.S.C. §1397cc(e)(3), provides for a 30 day grace period for non-payment of a premium and at least a 7 day notice at the end of the grace period that failure to pay the premium will result in termination from the program. We could not find that provision in the rules.</p>	<p>Clarified rule.</p> <p>Our responses to comments from Chapter 22 apply here as well.</p> <p>The grace period concerned is addressed in the current R9-31-1418.</p>

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters are applicable.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The rule does not require a permit.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

The rule implements 42 USC 1396a as amended by the Affordable Care Act, and federal regulations at 42 CFR Part 435, which, in relevant part, mandates certain changes to encompass more eligible persons (e.g., foster children up to age 26 and children with household income between 100% and 133% of the federal poverty level) and implements optional changes to provide coverage to more persons (childless adults). In addition, that federal law and the implementing regulations mandate certain changes to the methods for determining eligibility. These rules follow those federal directives and parameters, therefore these rules are not more stringent than federal law.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:

None

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
CHILDREN'S HEALTH INSURANCE PROGRAM**

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Section

- R9-31-301. ~~General Requirements~~ Expenditure limit and enrollment
- R9-31-302. ~~Applications~~ General Requirements
- R9-31-303. Eligibility Criteria
- R9-31-304. Income Eligibility
- R9-31-305. Verification
- R9-31-306. Enrollment
- R9-31-308. Changes and Redeterminations
- R9-31-309. Newborn Eligibility
- R9-31-310. Notice Requirements

ARTICLE 14. PREMIUMS FOR A CHILD DETERMINED ELIGIBLE UNDER ARTICLE 3

Section

- R9-31-1402. Premium Amount for a Member who is a Child Determined Eligible Under Article 3 of this Chapter
- R9-31-1416. Allocation of Payment for an Eligible Member
- R9-31-1420. Payment of a Premium

~~ARTICLE 17. ELIGIBILITY, ENROLLMENT AND COST SHARING FOR A PARENT~~ Repeal

Section

- R9-31-1701. ~~General~~ Repeal
- R9-31-1702. ~~Application~~ Repeal
- R9-31-1703. ~~Parent Eligibility Criteria~~ Repeal
- R9-31-1704. ~~Income~~ Repeal
- R9-31-1705. ~~Citizenship~~ Repeal
- R9-31-1706. ~~Residency~~ Repeal
- R9-31-1707. ~~Social Security Number (SSN)~~ Repeal
- R9-31-1708. ~~Age~~ Repeal
- R9-31-1709. ~~Ineligibility for Title XIX~~ Repeal
- R9-31-1710. ~~Institutionalized Person~~ Repeal
- R9-31-1711. ~~Other Health Coverage~~ Repeal
- R9-31-1712. ~~State Health Benefits~~ Repeal
- R9-31-1713. ~~Prior Health Insurance Coverage~~ Repeal
- R9-31-1716. ~~Verification~~ Repeal
- R9-31-1717. ~~Assignment of Rights~~ Repeal
- R9-31-1718. ~~Approval and Effective Date of Eligibility~~ Repeal
- R9-31-1719. ~~Enrollment~~ Repeal
- R9-31-1720. ~~Change and Redetermination~~ Repeal
- R9-31-1721. ~~Denial of Eligibility~~ Repeal
- R9-31-1722. ~~Discontinuance of Eligibility and Notice Requirements~~ Repeal
- R9-31-1723. ~~Newborn Eligibility~~ Repeal
- R9-31-1724. ~~Premium and Enrollment Fees~~ Repeal
- R9-31-1725. ~~Appeal and Request for Hearing Process~~ Repeal
- R9-31-1726. ~~Payment of Outstanding Premium and Enrollment Fees~~ Repeal
- R9-31-1727. ~~Payment Due Date for Current Month~~ Repeal
- R9-31-1728. ~~Payment Received Date~~ Repeal
- R9-31-1729. ~~Past Due Payment~~ Repeal
- R9-31-1730. ~~Payment Type~~ Repeal
- R9-31-1731. ~~Returned Check~~ Repeal
- R9-31-1732. ~~Payment In Advance~~ Repeal
- R9-31-1733. ~~Reimbursement of a Premium~~ Repeal

Notices of Final Rulemaking

R9-31-1734. Allocation of Payment for an Eligible Member Repeal

R9-31-1735. Change in Premium Amount Repeal

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-31-301. General Requirements Expenditure Limit and Enrollment

~~A.~~ Administration. The Administration shall administer the program as specified in A.R.S. § 36-2982.

~~B.~~ Operational authority. The Director has full operational authority to adopt rules or to use the appropriate rules for the development and management of an eligibility and enrollment system as specified in A.R.S. § 36-2986.

~~C.~~ Expenditure limit and enrollment

1. Title XXI will accept enrollees subject to the availability of funds. If the Director determines that monies may be insufficient for the program, the Administration shall stop processing applications for the program as specified in A.R.S. § 36-2985.
2. After the Administration has verified that funding is sufficient, it will resume processing applications as specified in A.R.S. § 36-2985.
3. The Administration shall immediately stop processing all applications and shall provide advance notice to a member that the program will terminate under A.R.S. § 36-2985.
4. A child is not entitled to a hearing under ~~Article 8 of this Chapter 34~~, if the program is suspended or terminated.

R9-31-302. Applications General Requirements

~~A.~~ Availability. The provisions in A.A.C. R9-22-1405(B) apply to this Section. The Administration shall make available program applications. Any person may request a program application.

~~B.~~ Submission of applications. An application is completed and submitted to the Administration:

1. In person;
2. By mail;
3. By fax; or
4. By other form approved by the Administration.

~~C.~~ Date of application. The date of application is the date the Administration or its designee receives an application that:

1. Is signed by the person making the application;
2. Includes the name of the person for whom assistance is requested; and
3. Includes the address and telephone number of the person submitting the application.

~~D.~~ Completed application:

1. The provisions in A.A.C. R9-22-1405(E) apply to this Section.
2. The Administration shall consider an application complete when:
 - a. All questions are answered;
 - b. An enrollment choice is included; and
 - c. All necessary verification is provided by an applicant or an applicant's representative.
3. If the application is incomplete, the Administration shall do one or both of the following:
 - a. Contact an applicant or an applicant's representative by telephone to obtain the missing information required for an eligibility determination;
 - b. Mail a request for additional information to an applicant or an applicant's representative, allowing 10 days from the date of the request to provide the required additional information.

~~A.~~ Administration. The Administration or its designee shall administer the program as specified in A.R.S. § 36-2982. The requirements described under Chapter 22, Article 3, except for R9-22-303, R9-22-305(1), R9-22-306(A)(4)(a) and (b), R9-22-306(B)(2)(b) and (c), R9-22-306(B)(3)(c)(iv), (vii) and (xi), R9-22-306(B)(4), R9-22-306(B)(5) and R9-22-307, apply to this Chapter.

~~E-B.~~ Eligibility determination processing time.

1. When an application is complete, the Administration or its designee shall mail notification to the applicant regarding the eligibility determination no more than 30 days from the date of application except when there is an emergency beyond the Administration's or its designee's control.
2. An applicant shall provide the Administration with all requested information within 10 days from the date of the written request for the information. If an applicant fails to provide the requested information and fails to request an extension of the 10 day period or the request for extension is denied, the Administration shall deny eligibility.

~~F.~~ Waiting list. If the Administration stops processing an application because the monies are insufficient as specified in R9-31-301(C)(1), the Administration shall place an applicant on a waiting list and notify the applicant. When sufficient funding becomes available, the Administration shall contact an applicant on the waiting list and ask the applicant to submit a new application if the original application is more than 60 days old. The Administration shall fill spaces in the order that an application is received and approved.

R9-31-303. Eligibility Criteria

Eligibility. To be eligible for the program, an applicant shall meet all the following eligibility requirements in addition to R9-

Notices of Final Rulemaking

31-302:

1. Age. Is less than 19 years of age. A child's coverage shall continue through the month in which a child turns age 19 if the child is otherwise eligible;
2. ~~Citizenship. Is a United States citizen or a qualified alien under A.R.S. § 36-2983;~~
3. ~~Residency. Is a resident of the state of Arizona under A.R.S. § 36-2983. An Arizona resident is a person who currently lives in Arizona and intends to remain in Arizona indefinitely;~~
4. ~~Income. Meets the income requirements in R9-31-304;~~
5. ~~Cost sharing. Pays the cost sharing premium amount when premiums are required as specified in A.R.S. §§ 36-2982 and 36-2903.01;~~
6. ~~Social security number (SSN). Provides a SSN or applies for a SSN within 30 days after submitting an application.~~
7. ~~Assignment. Assigns rights to any first- or third-party coverage of medical care as specified in 9 A.A.C. 31, Article 10;~~
8. ~~Other federal program. Is not eligible for Medicaid or other federally operated or financed health care insurance program, except the Indian Health Service as specified in A.R.S. § 36-2983;~~
9. ~~Inmate of a public institution. Is not an inmate of a public institution, as specified in A.R.S. § 36-2983;~~
10. ~~5. Patient in an institution for mental disease. Is not a patient in an institution for mental disease at the time of application, or at the time of redetermination, as specified in A.R.S. § 36-2983;~~
11. ~~6. Other health coverage. Is not covered under:~~
 - a. An employer's group health insurance plan,
 - b. Family or individual health insurance, or
 - c. Other health insurance;
12. ~~7. State health benefits. Is not a member of a family that is eligible for health benefits coverage under a state health benefit plan based on a family member's employment with a public agency in the state of Arizona;~~
13. ~~8. Prior health insurance coverage. Has not been covered by health insurance during the previous three months 90 days unless that health insurance was discontinued due to the involuntary loss of employment or other involuntary reason as specified in A.R.S. § 36-2983. The three months 90 days of ineligibility due to previous insurance coverage shall not apply to a child if:~~
 - a. ~~A newborn as defined in R9-31-309;~~
 - b. ~~A Title XIX member as specified in 9 A.A.C. 22, Article 1;~~
 - c. ~~An applicant who is seriously ill under R9-31-101 or chronically ill under A.R.S. § 36-2983;~~
 - d. ~~A member under this Article who loses insurance coverage;~~
 - e. ~~A CRS member; or~~
 - f. ~~A Native American member receiving services from IHS or a Tribal Facility.~~
 - a. Following the loss of eligibility for and enrollment in Medicaid or another insurance affordability program;
 - b. The premium paid by the family for coverage of the child under the group health plan exceeded 5 percent of household income;
 - c. The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Exchange because the ESI in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v);
 - d. The cost of family coverage that includes the child exceeds 9.5 percent of the household income;
 - e. The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan;
 - f. A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA);
 - g. The child has special health care needs; or
 - h. The child lost coverage due to the death or divorce of a parent.

R9-31-304. Income Eligibility

- A. Income standard. The combined gross income of the household income group members as specified in subsection (C) shall not exceed the percentage of the appropriate FPL under A.R.S. § 36-2981 for the Title XXI household income group size.
- B. Calculating monthly income. The Administration or its designee shall calculate monthly income under R9-22-1423 A.A.C. R9-22-1419.01(B) through 1419.04.
- C. ~~Title XXI household income group~~ The Administration or its designee shall include the income of persons described under R9-22-1420(B).
 1. ~~For this Section:~~
 - a. ~~"Child" means a person less than 19 years of age or an unborn child.~~
 - b. ~~"Parent" means a biological, adoptive, or step parent.~~
 2. The following related persons, when residing together, constitute a Title XXI household income group:
 - a. A married couple and children of either one or both;

Notices of Final Rulemaking

- b. ~~An unmarried couple with a common child and at least one other child of either one or both;~~
 - e. ~~A married couple when one or both are under age 19 with no child;~~
 - d. ~~A single parent and the single parent's child;~~
 - e. ~~A child who does not live with a parent; and~~
 - f. ~~The following persons, when living with a child:~~
 - i. ~~A spouse of the child;~~
 - ii. ~~A child of the spouse child;~~
 - iii. ~~A child of the child; and~~
 - iv. ~~The other parent of a child of the child.~~
 - 3. ~~A member of the household income group who is absent from a household shall be included in the child's household income group if absent:~~
 - a. ~~For 30 days or less;~~
 - b. ~~For the purpose of seeking employment or to maintain a job;~~
 - e. ~~For serving in the military; or~~
 - d. ~~For an educational purpose and the child's parent claims the child as a dependent on the parent's income tax return.~~
- D.** ~~Income disregards. When determining gross income of the household, the Administration or its designee shall disregard income as described under R9-22-1421(A), the following:~~
- 1. ~~Income specified in 20 CFR 416, Appendix to subpart K as of June 6, 1997, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments;~~
 - 2. ~~Income paid according to federal law that prohibits the use of the income when determining eligibility for public benefits;~~
 - 3. ~~Money received as the result of the conversion of an asset;~~
 - 4. ~~Income tax refunds; and~~
 - 5. ~~An amount equal to the expenses of producing self-employment income from the gross self-employment income.~~
- E.** ~~Effective date of initial eligibility.~~
- 1. ~~For an eligibility determination completed by the 25th day of the month, eligibility shall begin on the first day of the month following the determination of eligibility.~~
 - 2. ~~For an eligibility determination completed after the 25th day of the month, eligibility shall begin on the first day of the second month following the determination of eligibility.~~

R9-31-305. Verification

Verification. An applicant or a member shall provide the Administration or its designee with verification or authorize the release of verification to the Administration or its designee of all information necessary to complete the determination of eligibility as described under R9-22-304.

R9-31-306. Enrollment

- ~~A.~~ Selection choices. Enrollment requirements applicable to the KidsCare program are described under Chapter 22, Article 17.
- 1. ~~Except as provided in subsections (A)(3), (4), and (5), at the time of application, an applicant shall select from the following enrollment choices:~~
 - a. ~~A contractor which includes a contractor or a qualifying plan as defined in A.R.S. § 36-2981, or~~
 - b. ~~The IHS as specified in A.R.S. § 36-2982. If a member is enrolled with the IHS, a member may elect to receive covered services from a participating Tribal Facility.~~
 - 2. ~~Except as provided in subsections (A)(3), (4), and (5), coverage shall not begin until a Title XXI enrollment choice is made.~~
 - 3. ~~The Administration shall enroll a member with CMDP when a member is a foster care child according to A.R.S. § 8-542.~~
 - 4. ~~When a Title XIX member becomes ineligible for Title XIX and DES determines the member eligible for Title XXI with no break in coverage,~~
 - a. ~~The Title XXI member shall remain enrolled with the Title XIX contractor; and~~
 - b. ~~The Administration shall send the Title XXI member a notice explaining the member's right to choose as specified in subsection (A)(1).~~
 - 5. ~~When an applicant applies for Title XIX through DES and DES determines the applicant ineligible for Title XIX but eligible for Title XXI, the Administration shall enroll the applicant for Title XXI as follows:~~
 - a. ~~If a Title XIX contractor pre-enrollment choice is pending at the time the Administration receives the Title XXI approval from DES, the Administration may:~~
 - i. ~~Enroll member with the Title XIX contractor; and~~
 - ii. ~~Notify the member of the member's enrollment and provide the member an opportunity to select an enroll-~~

Notices of Final Rulemaking

- ment choice as specified in subsection (A)(1).
- b. If there is no pending Title XIX choice at the time the Administration receives the Title XXI approval from DES, the Administration shall pend the Title XXI decision and obtain a choice from the member as specified in subsection (A)(1).
- B. Effective date of initial enrollment.**
- 1. For an eligibility determination completed by the 25th day of the month, enrollment shall begin on the first day of the month following the determination of eligibility.
 - 2. For an eligibility determination completed after the 25th day of the month, enrollment shall begin on the first day of the second month following the determination of eligibility.
- C. Enrollment changes.**
- 1. If a member moves from one GSA to another GSA during the period of enrollment, enrollment changes shall occur as follows:
 - a. If a member's current enrollment choice is available in a member's new GSA, a member shall remain enrolled with the member's current enrollment choice.
 - b. If a member's current enrollment choice is not available in the new GSA, a member shall:
 - i. Remain enrolled with the current enrollment choice. The current enrollment choice may limit services to emergency services outside the GSA as specified in R9-31-201.
 - ii. Select from the enrollment choices provided in R9-31-306(A)(1) that are available in the new GSA. Once a new choice is made, a member shall be enrolled with the new choice effective with the date the Administration processes the member's enrollment choice. Covered services shall be available on the date of the enrollment change.
 - 2. A member may change a member's enrollment choice:
 - a. During a member's annual enrollment choice period;
 - b. At any time from:
 - i. IHS to a contractor as specified in subsection (A)(1) of this Section; or
 - ii. A contractor to IHS.
 - c. When a member is no longer a foster care child as specified in subsection (A)(3) of this Section.
 - 3. Except for subsection (C)(2)(c) of this Section, the effective date of the new enrollment choice is the date the Administration processes the enrollment choice. The effective date of the enrollment change from CMDP to a Title XXI choice as specified in subsection (A)(1) of this Section, shall be the first of the following month.
- D. Annual enrollment choice period.** A member shall have the opportunity to change enrollment no later than 12 months following the last time a member made an enrollment choice or had the opportunity to make an enrollment choice.
- E. Health Insurance Portability and Accountability Act of 1996.** As specified in A.R.S. § 36-2982, a Title XXI member who has been disenrolled shall be allowed to use enrollment in the Title XXI program as creditable coverage as defined in A.R.S. § 36-2984.

R9-31-308. Changes and Redeterminations

- A. Reporting Changes.** A member or a member's parent or guardian shall report the following changes to the Administration or its designee:
- 1. Any increase in income that will begin or continue into the following month,
 - 2. Any change of address,
 - 3. The addition or departure of a household member,
 - 4. Any health coverage under private or group health insurance,
 - 5. Employment of a member or a parent with a state agency, and
 - 6. Incarceration of a member; and
 - 7. Any other changes that may impact eligibility or premiums.
- B. Verification.** If required verification is needed and requested as a result of a change specified in subsection (A) of this Section to determine the impact on eligibility or premiums and is not received within 10 days, the Administration or its designee shall send a notice to discontinue eligibility for a member unless a member is within the guaranteed eligibility enrollment period as specified in R9-31-307.
- C. Redeterminations.** The renewal eligibility requirements described under R9-22-306 for a KidsCare program member shall be followed. If no change is reported, the Administration shall initiate redetermination no later than the end of the 12th month after the effective date of eligibility, or the completion of the most recent redetermination decision whichever is later.
- D. Termination.** The termination notice requirements as described under R9-22-307 for a KidsCare program member shall be followed. If the Administration determines that a child no longer meets the eligibility criteria, or a head of household fails to respond or cooperate with the redetermination of eligibility, the Administration shall terminate coverage.

R9-31-309. Newborn Eligibility

- A. Eligibility.** A child born to a Title XXI member, is eligible for 12 months of coverage without filing an application under

Notices of Final Rulemaking

Title XXI provided:

1. The child continues to live with the child's mother during the 12-month period; and
 2. One of the events as specified in R9-31-307(A) does not occur.
- B.** Deemed Coverage. A newborn's deemed newborn coverage shall begin effective with a newborn's date of birth and end with the last day of the month in which a newborn turns age 1. Deemed newborn status does not preclude a child from ~~applying being approved~~ for Title XIX ~~and being approved~~.
- C.** Enrollment choice for a newborn. A newborn shall be enrolled with a mother's enrollment choice as specified in contract.
- D.** Notification of enrollment. The Administration or its designee shall notify a mother of a newborn's enrollment and provide a mother an opportunity to select an enrollment choice as specified in ~~R9-31-306(A)(1)~~ Chapter 22, Article 17.

R9-31-310. Notice Requirements

- ~~**A.** Notice Requirements. The notice requirements as described in R9-22-312 apply to this Chapter. Applications. Upon completion of a determination of eligibility or ineligibility for any child in the household, the Administration shall issue a written notice to an individual who initiated the application. This notice shall include a statement of the intended action, an explanation of a person's hearing rights as specified in 9 A.A.C. 31, Article 8, and:~~
- ~~1. If approved, the notice shall contain the name and effective date of eligibility for each approved applicant;~~
 - ~~2. If denied, the notice shall contain:~~
 - ~~a. The name of each ineligible applicant;~~
 - ~~b. The effective date of the denial;~~
 - ~~c. The reasons for ineligibility including appropriate income calculations and income standard when the reason for the denial is based on excess income;~~
 - ~~d. The legal authority supporting the reason for ineligibility; and~~
 - ~~e. The resource or reference materials where the legal authority citations are found.~~
- B. Terminations:**
- ~~1. When the Administration proposes a termination of Title XXI eligibility, the Administration shall provide a member with:~~
 - ~~a. Advance notice at least 10 days before the effective date of the adverse action except as provided in subsection (B)(1)(b);~~
 - ~~b. Adequate notice no later than the date of adverse action when a member:~~
 - ~~i. Voluntarily withdraws and indicates an understanding of the results of the action;~~
 - ~~ii. Becomes an inmate of a public institution as specified in R9-31-303(I);~~
 - ~~iii. Dies and the Administration has verification of the death;~~
 - ~~iv. Has whereabouts that are unknown and the Administration's loss of contact is confirmed by returned mail from the post office with no forwarding address; or~~
 - ~~v. Is approved for Title XIX.~~
 - ~~2. In addition to the requirements listed in subsection (A)(2), the termination notice shall include an explanation of a member's right to continued Title XXI coverage pending a request for hearing as provided in 9 A.A.C. 31, Article 8 and 14.~~

ARTICLE 14. PREMIUMS FOR A CHILD DETERMINED ELIGIBLE UNDER ARTICLE 3

R9-31-1402. Premium Amount for a Member who is a Child Determined Eligible Under Article 3 of this Chapter

- A.** For the purposes of this Article, a premium is a monthly amount that an enrolled member pays to the Administration to remain eligible for Title XXI.
- B.** When the household income is greater than the income limit described under R9-22-1427(D) ~~100 percent of the FPL~~ and less than or equal to 150 percent of the FPL, the monthly premium is \$10 for one eligible child and \$15 for two or more eligible children.
- C.** When household income is greater than 150 percent of the FPL and less than or equal to 175 percent of the FPL, the monthly premium payment is \$40 for one eligible child and \$60 for two or more eligible children.
- D.** When household income is greater than 175 percent of the FPL and less than or equal to 200 percent of the FPL, the monthly premium is \$50 for one eligible child and \$70 for two or more eligible children.
- E.** A household's premium payments as specified in this Section shall not exceed five percent of a household's gross income.
- F.** A member's newborn is enrolled immediately upon the Administration receiving notification of the child's birth. Upon enrollment, the household's premium is redetermined.
- G.** To remain eligible, the premium amount shall be paid according to this Article.
- H.** ~~Native Americans~~ American Indians are exempt from paying premiums.
- ~~**I.** When a premium is paid for a household including the parents of a child eligible under Article 3 as described in Article 17, no separate premium is charged for the child under this Section.~~

R9-31-1416. Allocation of Payment for an Eligible Member

Except for payments specified in R9-31-1419 of this Article, all payments received for eligible members shall first be applied

Notices of Final Rulemaking

to any past due amounts for prior months owed to the Administration for a child determined eligible under Article 3 of this Chapter, next to the unpaid enrollment fee for a parent eligible under Article 17, and then to the past due amounts for prior months owed to the Administration for a parent determined eligible under Article 17 of this Chapter. Any remaining amounts shall first then be applied to the amount due for the current month for a child eligible under Article 3 of this Chapter and then to the amount due for the current month for a parent, eligible under Article 17 of this Chapter.

R9-31-1420. Payment of a Premium

When a member was discontinued with an unpaid premium, the parent or other responsible person shall pay the past due premium amounts for a child to the Administration or the child will remain ineligible for 90 days before the person can attain eligibility again. before eligibility for the child under this Article can be approved.

ARTICLE 17. ~~ELIGIBILITY, ENROLLMENT AND COST SHARING FOR A PARENT~~ Repeal

R9-31-1701. General Repeal

A. Purpose. This Article contains the criteria to determine the eligibility, enrollment, and cost sharing for a parent under A.R.S. §§ 36-2982, 36-2983 and Laws 2006, Ch. 331, § 32. Unless otherwise noted in this Chapter, the provisions of this Chapter apply to a parent eligible under this Article.

B. Expenditure limit and enrollment

1. Eligibility of a parent shall be based on the FPL established in Laws 2006, Ch. 331, § 32, subject to the availability of monies. If the Director determines that monies are insufficient for the program, the eligibility agency shall suspend accepting new applications and shall deny all pending applications.
2. If the federal government eliminates federal funding for the program, the eligibility agency shall deny all pending applications and shall discontinue an eligible parent after providing advance notice that the program shall terminate under A.R.S. § 36-2985.
3. A parent is not entitled to a hearing under R9-31-1724 of this Article, if the program is suspended or terminated.

C. Definition

1. For the purposes of this Article, a child is:
 - a. A child, except for a deemed newborn, under A.R.S. § 36-2901(6)(a)(ii), who is determined eligible under 9 A.A.C. 22, Article 14, or
 - b. A child, except for a deemed newborn, under A.R.S. § 36-2981(6) who is determined eligible under Article 3 of this Chapter. A child in the guaranteed enrollment period under R9-31-307 or a newborn under R9-31-309, is not considered a child under this Article.
2. For the purposes of this Article, a parent is defined under Laws 2006, Ch. 331, § 32 and also includes a stepparent. A parent of an 18-year-old child under subsection (C)(1)(a) is not eligible under this Article.
3. For the purposes of this Article, eligibility agency means either DES or the Administration, whichever agency made the eligibility determination for the child.

D. Services. A parent eligible under this Article shall receive medically necessary services under 9 A.A.C. 22, Article 2.

R9-31-1702. Application Repeal

A. Application form. A parent who wants to apply for eligibility under this Article shall apply using an application approved by the Administration.

B. Application process. For a parent of a child under R9-31-1701(C)(1)(a), the Administration shall process an application under A.A.C. R9-22-1405(A) through (F), R9-22-1411(A) and (C), and R9-22-1407. For a parent of a child under R9-31-1701(C)(1)(b), the Administration shall process an application under R9-31-302(A) through (E).

R9-31-1703. Parent Eligibility Criteria Repeal

To be eligible, a parent shall be a parent of, and living with, a child as defined in R9-31-1701(C).

R9-31-1704. Income Repeal

To be eligible, the countable income shall be determined under R9-31-304 and shall not exceed the percentage of FPL established in Laws 2006, Ch. 331, § 32. For a parent of a child under R9-31-1701(C)(1)(a), the countable income shall include a stepparent's income if the stepparent is applying.

R9-31-1705. Citizenship Repeal

To be eligible, a parent shall be a United States citizen or a qualified alien as specified in A.R.S. § 36-2903.03(B).

R9-31-1706. Residency Repeal

To be eligible, a parent shall be a current resident of the state of Arizona.

R9-31-1707. Social Security Number (SSN) Repeal

To be eligible, a parent shall provide a SSN or apply for a SSN within 30 days after submitting an application.

R9-31-1708. Age Repeal

To be eligible, a parent shall be age 19 or older.

Notices of Final Rulemaking

R9-31-1709. ~~Ineligibility for Title XIX Repeal~~

To be eligible, a parent shall not be eligible for Title XIX under A.R.S. § 36-2901(6). A parent is not eligible under this Article if ineligibility for Title XIX is due to the parent's refusal to apply for Title XIX or the parent's noncompliance with a Title XIX eligibility requirement.

R9-31-1710. ~~Institutionalized Person Repeal~~

To be eligible, a parent shall not be an inmate of a public institution or a patient in an IMD under A.R.S. § 36-2983(G), unless federal financial participation is available.

R9-31-1711. ~~Other Health Coverage Repeal~~

To be eligible, a parent shall not be covered under an employer's group health insurance plan, family or individual health insurance, or other health insurance, including Medicare. Eligibility for the Indian Health Service is not considered other health coverage.

R9-31-1712. ~~State Health Benefits Repeal~~

To be eligible, a parent shall not be eligible for health coverage under a state health benefit plan based on a family member's employment with a public agency in the state of Arizona.

R9-31-1713. ~~Prior Health Insurance Coverage Repeal~~

To be eligible, a parent shall not have been covered by health insurance as defined in R9-31-1711 or R9-31-1712 of this Article, during the previous three months, unless that health insurance was discontinued due to the involuntary loss of employment or other involuntary reason.

R9-31-1716. ~~Verification Repeal~~

To be eligible, a parent shall provide verification or authorize the release of verification for all information necessary to complete the determination of eligibility.

R9-31-1717. ~~Assignment of Rights Repeal~~

To be eligible, a parent shall assign rights to any first- or third-party coverage of medical care as specified in Article 10 of this Chapter.

R9-31-1718. ~~Approval and Effective Date of Eligibility Repeal~~

A. Approval. An eligibility approval under this Article shall be determined by the Administration. The Administration shall follow the approval notice requirements in R9-31-310(A).

B. Effective date of eligibility. The effective date of eligibility is the later of one of the following:

1. The first day of the month following the eligibility determination for a determination made on or before the 25th day of the month;
2. The first day of the second month following the eligibility determination for a determination made after the 25th day of the month; or
3. The first day of the month in which the parent meets all eligibility requirements in this Article.

R9-31-1719. ~~Enrollment Repeal~~

There is no guaranteed enrollment period for a parent eligible under this Article.

R9-31-1720. ~~Change and Redetermination Repeal~~

A. Reporting a change. A parent eligible under this Article shall report the following changes to the eligibility agency:

1. An increase or decrease in income;
2. A change of address;
3. A move out of state;
4. An addition or departure of a household member;
5. Any health coverage under private or group health insurance;
6. Eligibility for health coverage under a state health benefit plan based on a family member's employment with a public agency in the state of Arizona;
7. Incarceration of a member;
8. Becoming an inpatient in an IMD; and
9. Receipt of a SSN.

B. Verification. If required verification is needed and requested by the eligibility agency as a result of a change specified in subsection (A), to determine the impact on eligibility, and is not received within 10 days, the Administration shall send a notice to discontinue eligibility.

C. Redetermination. The eligibility agency shall complete a redetermination of each parent's eligibility at least once every 12 months.

R9-31-1721. ~~Denial of Eligibility Repeal~~

A. For a parent of a child under R9-31-1701(C)(1)(a):

Notices of Final Rulemaking

1. ~~DES shall deny eligibility under this Article if the parent does not meet a requirement under this Article except for R9-31-1726 of this Article. DES shall follow the denial notice requirements in A.A.C. R9-22-1411(C); and~~
 2. ~~The Administration shall deny eligibility under this Article if the parent does not meet the requirement under R9-31-1726 of this Article. The Administration shall follow the denial notice requirements under R9-31-310(A)(2).~~
- B.** ~~For a parent of a child under R9-31-1701(C)(1)(b), the Administration shall deny eligibility under this Article if any one of the conditions of eligibility listed in this Article is not met. The Administration shall follow the denial notice requirements under R9-31-310(A)(2).~~

R9-31-1722. Discontinuance of Eligibility and Notice Requirements Repeal

- A.** ~~The Administration shall discontinue eligibility under this Article if any one of the conditions of eligibility listed in this Article is not met.~~
- B.** ~~The Administration shall send an adverse action notice to discontinue eligibility if the Administration does not receive a payment that is equal to the past and current due premium amounts by the 15th day of the current month.~~
- C.** ~~The Administration shall follow the discontinuance notice requirements under R9-31-310(B).~~

R9-31-1723. Newborn Eligibility Repeal

A child born to a mother eligible under R9-31-1701(C)(1)(a) shall follow the newborn eligibility under R9-22-1422. A child born to a mother eligible under R9-31-1701(C)(1)(b) shall follow the newborn eligibility under R9-31-309.

R9-31-1724. Premium and Enrollment Fees Repeal

- A.** ~~For the purposes of this Article:~~
1. ~~A premium is a monthly payment that an enrolled member pays to the Administration to remain eligible.~~
 2. ~~An enrollment fee is the amount required by subsection (C)(4), which shall be paid to the Administration by a member who is a parent determined eligible under this Article. The enrollment fee and the first month's premium will be billed and due concurrently with the first month's payment.~~
 3. ~~To remain eligible, a parent shall pay the premium amount and enrollment fee according to this Article.~~
- B.** ~~Premiums~~
1. ~~When countable income is equal to or greater than 100 percent but less than 150 percent of the FPL, the monthly premium for the family is three percent of the countable income.~~
 2. ~~When countable income is equal to or greater than 150 percent but less than 175 percent of the FPL, the monthly premium for the family is five percent of the countable income.~~
 3. ~~When countable income is equal to or greater than 175 percent but less than or equal to 200 percent of the FPL, the monthly premium for the family is five percent of the countable income.~~
 4. ~~Native Americans are exempt from paying premiums.~~
 5. ~~When a premium is paid for a household including the parents of a child eligible under Article 3 as described in Article 17, no separate premium is charged for the child under this Section.~~
- C.** ~~Enrollment Fees~~
1. ~~A parent enrolled on or after January 1, 2005 will be charged an enrollment fee.~~
 - a. ~~If a parent who has paid the enrollment fee does not receive coverage under this Article for a period of at least 24 months, the parent will be charged another enrollment fee if the parent is approved again under this Article.~~
 - b. ~~If a parent who has paid the enrollment fee is discontinued under this Article for a period of less than 24 months, the parent will not be charged an enrollment fee when the parent is approved again.~~
 2. ~~A parent who was enrolled before January 1, 2005 will not be charged an enrollment fee unless the parent is discontinued under this Article and approved again.~~
 3. ~~Native Americans are exempt from paying the enrollment fee.~~
 4. ~~The enrollment fee amount:~~
 - a. ~~For each eligible parent is \$15 when countable income is less than or equal to 150 percent of the FPL.~~
 - b. ~~For each eligible parent is \$20 when countable income is greater than 150 percent of the FPL and less than or equal to 175 percent of the FPL.~~
 - c. ~~For each eligible parent is \$25 when countable income is greater than 175 percent of the FPL and less than or equal to 200 percent of the FPL.~~

R9-31-1725. Appeal and Request for Hearing Process Repeal

- A.** ~~Denial. If DES denies a parent under R9-31-1721 of this Article, the appeal and request for hearing process shall be conducted under A.A.C. R9-22-1433. If the Administration denies a parent under R9-31-1721 of this Article, the appeal and request for hearing process shall be conducted under 9 A.A.C. 34.~~
- B.** ~~Discontinuance. If the Administration discontinues a parent under R9-31-1722 of this Article, the appeal and request for hearing process shall be conducted under 9 A.A.C. 34.~~
- C.** ~~Coverage for Discontinuance. Except as provided in this Section, the Administration shall discontinue eligibility on the effective date of the discontinuance if the past due amount for at least one prior month is not received by the Administration in full before the effective date of the discontinuance.~~

Notices of Final Rulemaking

- D.** ~~Discontinuance rescinded. The Administration shall rescind the discontinuance and continue eligibility if the past due amount for at least one prior month is received by the Administration in full before the effective date of the discontinuance.~~
- E.** ~~Discontinuance of eligibility. To receive coverage from the time an appeal and request for hearing is filed for a discontinuance of eligibility until a Director's decision is made:~~
- ~~1. A member shall:~~
 - ~~a. File an appeal and request for hearing prior to the effective date of the discontinuance.~~
 - ~~b. Submit the full monthly premium amount to the Administration prior to the date of the discontinuance, and~~
 - ~~c. Continue to pay the full monthly premium amount each month during the hearing process.~~
 - ~~2. Failure of the member to pay the full monthly premium shall result in the loss of eligibility effective the first day of the next month.~~
 - ~~3. If the decision is upheld, the Administration shall not refund any premium amounts that have been paid during the hearing process.~~
- F.** ~~Increase in premium amount. To stop the Administration from increasing the premium amount from the time an appeal and request for hearing is filed until a Director's decision is made:~~
- ~~1. A member shall file an appeal and request for hearing prior to the effective date of the action.~~
 - ~~2. If the decision to increase the premium is upheld, the member shall be responsible for paying the higher premium retroactively from the proposed effective date of the increase in the premium amount that is being appealed.~~
- G.** ~~Imposition of an enrollment fee and premium. To receive coverage from the time an appeal and request for hearing is filed for an imposition of an enrollment fee and premium until a Director's decision is made:~~
- ~~1. A member shall file an appeal and request for hearing in accordance with the time frame as specified in R9-34-107.~~
 - ~~2. A member shall pay the enrollment fee and premium as billed by the Administration.~~
 - ~~3. If the decision determines the imposition of the enrollment fee and premium is incorrect then the enrollment fee and premium will be refunded to the member.~~
- H.** ~~Method of payment. To continue coverage a member shall pay the premium by:~~
- ~~1. Cashier's check,~~
 - ~~2. Money order, or~~
 - ~~3. Other form approved by the Administration.~~

R9-31-1726. Payment of Outstanding Premium and Enrollment Fees Repeal

~~As a condition of eligibility, a parent shall be required to pay any unpaid enrollment fee and premiums owed to the Administration that were previously incurred. The unpaid enrollment fee and unpaid premiums consist of:~~

- ~~1. All unpaid enrollment fees and premiums for the parent that were incurred prior to becoming eligible,~~
- ~~2. All unpaid premiums for the parent's children, and~~
- ~~3. All unpaid enrollment fees and premiums for the parent's spouse with whom the parent resides, and with whom the parent resided at the time the premium and enrollment fee was incurred.~~

R9-31-1727. Payment Due Date for Current Month Repeal

- A.** ~~The monthly premium payment is due on the 15th day of the month for coverage of that month. This would be considered a current payment.~~
- B.** ~~The enrollment fee is due with the first monthly premium payment on the 15th day of the month for coverage. This would be considered a current payment.~~

R9-31-1728. Payment Received Date Repeal

~~A payment is considered received on the date that the Administration receives and credits the payment to the member's account.~~

R9-31-1729. Past Due Payment Repeal

- A.** ~~Past due payment date. A payment is considered past due if the Administration does not receive the payment by the 15th day of the month.~~
- B.** ~~Payment not received. If payment for a month is not received in full by the last working day of the month in which the payment is due, the Administration shall include the past and current due amounts in the next billing statement.~~

R9-31-1730. Payment Type Repeal

~~A premium and an enrollment fee shall be paid to the Administration by a:~~

- ~~1. Cashier's check,~~
- ~~2. Personal check,~~
- ~~3. Money order,~~
- ~~4. Electronic debit, or~~
- ~~5. Other form approved by the Administration.~~

R9-31-1731. Returned Check Repeal

Notices of Final Rulemaking

The Administration shall not accept a personal check when the premium or enrollment fee has been previously paid with a personal check that was returned to the Administration because of insufficient funds.

R9-31-1732. Payment In Advance Repeal

A premium may be paid in advance.

R9-31-1733. Reimbursement of a Premium Repeal

- A.** A premium paid in advance is nonrefundable, unless the member is disenrolled at least 15 days prior to the month of coverage.
- B.** A premium and enrollment fee paid during an appeal and request for hearing process is applied as specified in R9-31-1724.

R9-31-1734. Allocation of Payment for an Eligible Member Repeal

Except for payments specified in R9-31-1724 of this Article, all payments received for eligible members shall first be applied to any past due amounts for prior months owed to the Administration for a child determined eligible under Article 3 of this Chapter, next to the unpaid enrollment fee for a parent eligible under this Article, and then to the past due amounts for prior months owed to the Administration for a parent determined eligible under this Article. Any remaining amounts shall first be applied to the amount due for the current month for a child eligible under Article 3 of this Chapter and then to the amount due for the current month for a parent, eligible under this Article.

R9-31-1735. Change in Premium Amount Repeal

- A.** When there is a decrease in the premium amount and the change is processed by the 25th day of the month, then the effective date of the change shall begin on first day following the month in which the amount of the premium change is processed.
- B.** When there is a decrease in the premium amount and the change is processed after the 25th day of the month, then the effective date of the change shall begin on the first day of the second month in which the amount of the premium change is processed.
- C.** When there is an increase in the premium amount, the effective date of the change shall begin with the first month following advance notice of at least ten days.